RN

JUNE 1958

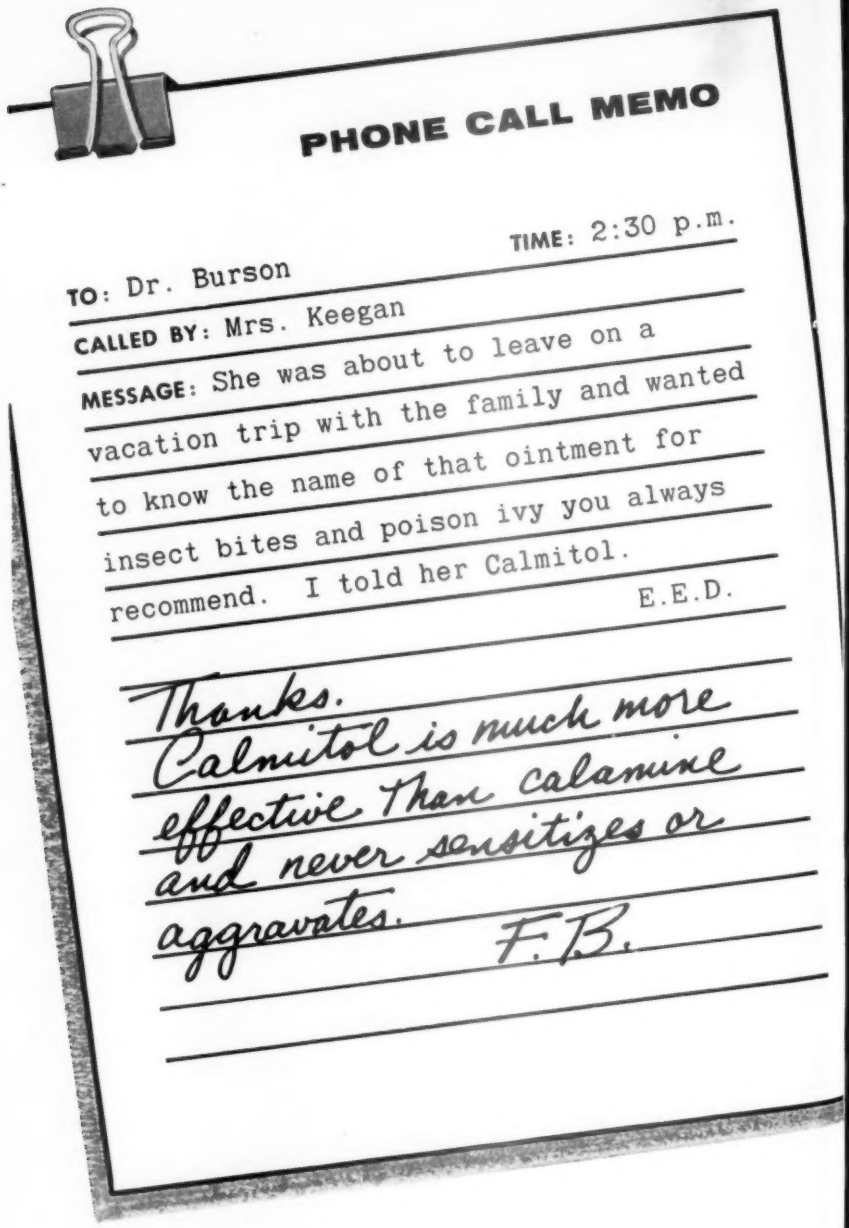
RESUSCITATION FOR CARDIAC ARREST

also . . .

Back to the Bedside: An Escape Mechanism?

also . . .

You Can Be Sued for That!



*Calmitol is the non-sensitizing antipruritic supplied as Ointment in 1½-oz. tubes and 1-lb. jars, and as Liquid, for more stubborn pruritus, in 2-oz. bottles by Thos. Leeming & Co., Inc., New York 17, N.Y. *Write for samples.*

RN contents

VOLUME 21 • NO. 6 • JUNE 1958

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MORE ►

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DEPARTMENTS

JUNE 1958

RN

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But surely...

the lady will be dainty

- Massengill Powder has a "clean" antiseptic fragrance. It enjoys unusual patient acceptance
- Massengill Powder is buffered to *maintain* an acid condition in the vaginal mucosa. It is more effective than vinegar and simple acid douches.
- Massengill Powder has a low surface tension which enables it to penetrate into and cleanse the folds of the vaginal mucosa.
- Massengill Powder solutions are easy to prepare. They are nonstaining, mildly astringent.

massengill® powder

when recommending a vaginal douche

INDICATIONS:

Massengill Powder solutions are a valuable adjunct in the management of monilia, trichomonas, staphylococcus, and streptococcus infections of the vaginal tract. Routine douching with Massengill Powder solution minimizes subjective discomfort and maintains a state of cleanliness and normal acidity without interfering with specific treatment.

Currently, mailings will be forwarded only at your request. Write for samples and literature.

The S. E. MASSENGILL Company BRISTOL, TENNESSEE

In modern feminine hygiene

and therapy

massengill® powder

The clean, refreshing fragrance of Massengill Powder is acceptable to the most fastidious for therapeutic or routine hygienic use. Solutions are easily prepared, convenient to use, nonstaining. They effectively cleanse, deodorize and soothe the vaginal mucosa, while their mild astringent properties tend to decrease vaginal secretions.

CLEAN-UP AFTER ANTIBIOTICS

Following intensive antibiotic therapy, many female patients complain of vulvar pruritus or vaginitis, and profuse vaginal discharge. Most of these present the classical picture of Monilia albicans, Trichomonas vaginalis or mixed infections. When these infections occur, regular use of Massengill Powder, with its pH of 3.5 to 4.5, helps restore the normal acidity of the vaginal tract. At this normal pH the growth of pathogenic organisms is inhibited and the growth of the normal vaginal flora encouraged.[1]

LOW pH RETENTION

Massengill Powder is buffered to retain an acid condition. In a recent study, ambulatory patients—with an alkaline vaginal mucosa resulting from pathogens—maintained an acid vaginal mucosa of pH 3.5 for a period of 4 to 6 hours after douching with Massengill Powder; recumbent patients maintained a satisfactory acid condition up to 24 hours. Simple acid douches are quickly neutralized by an alkaline vaginal mucosa, and are unsatisfactory in maintaining the required acid pH of the vagina.[2]

LOWER SURFACE TENSION

Massengill Powder in the standard solution has a surface tension of 50 dynes/cm. as compared to that of water and simple acid solutions with 72 dynes/cm. This added property enables Massengill Powder to penetrate into and cleanse the folds of the vaginal mucosa, thus increasing the therapeutic effectiveness. Lowered surface tension makes the cell wall and cytoplasmic membrane of the infecting organism more permeable and more susceptible to specific therapy.[2]

SUPPLY

Massengill Powder is supplied in glass jars of the following sizes:

Small, 3 oz.
Medium, 6 oz.
Large, 16 oz.
Hospital Size, 5 lbs.

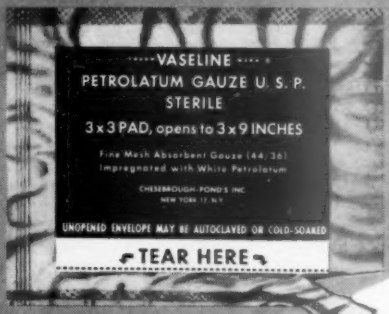
Pads of douching instructions for patient use available on request.

REFERENCES

1. Lang, W.R., Rakoff, A.E., Am. Geriatrics Soc. *1*:520 (1953).
2. Arnot, P.H., The Problem of Douching, Western Journal of Surg., Obs., and Gyn., Vol. 62, No. 2:85 (1954).

The S. E. MASSENGILL Company BRISTOL, TENNESSEE

The NEW DUAL PURPOSE



3″ x 3″ PAD

Three-ply, fine-mesh gauze, lightly impregnated — for use in physician's office, industrial medical department, first aid.

3″ x STR

Shorter length ends
on small area wounds. New
insures perfect graft
Guaranteed sterile at time o

6th SIZE of VASELINE® PETROLATUM GAUZ

Now supplied in:	1/2″x 72″	3″x 1
	1″x 36″	3″x 3
	3″x 3″/ 3″x 9″	6″x 3

Sole Maker:

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Professional Products Division

New York 17, N. Y.

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BETTER TOTAL EFFECT

in the relief of pain of

HEADACHE • NEURITIS • NEURALGIA

Anacin Tablets are optimally successful in the relief of simple pain. They exceed the benefits of plain aspirin and buffered aspirin by giving a 'better total effect.' That is, Anacin not only relieves the pain but also lessens emotional tension and leaves the patient more relaxed. The mild sedative action of phenacetin—double that of aspirin—induces a 'restful' state in which the reparative forces are nurtured. Tolerance is excellent. Anacin does not upset the stomach. Why not give consideration to Anacin as the non-narcotic analgesia of your choice?

ANACIN®

WHITEHALL LABORATORIES, NEW YORK 16, N.Y.

RN letters

'KEEP IT IMPERSONAL'

DEAR EDITOR: I don't agree with Amy Vanderbilt when she suggests that a woman patient may extend a social invitation to her nurse as a gesture of appreciation.

I believe the nurse-patient relationship should remain impersonal.

At some future time the nurse may again come in contact professionally with her ex-patients or their families. If, in the meanwhile, she has become emotionally involved with them, she may not be able to do her professional best.

Joan Freid, R.N.
Lynn, Mass.

FAT GIRL'S DREAM

DEAR EDITOR: After reading "Dieting That Works," I wonder whether the authors couldn't be persuaded to amend their awful pronouncement: "To reduce and stay reduced, you must establish a new way of eating—and follow it forever."

I have a mental picture of myself proudly (but sadly) carrying my frame down the straight and narrow 1,200-calories-a-day road year after year, ad infinitum. And such a lonely road it is!

I also wonder how my friends would respond to an invitation for an evening of Scrabble and a 100-calorie snack.

What are our medical researchers doing about this No. 1 health problem? Surely we can expect the future will offer something better than a steady diet of dieting.

Or is that just a fat girl's dream?

Rachel G. Francis, R.N.
Hill, N.H.

RX FOR MORE NURSES

DEAR EDITOR: Many servicemen, like myself, are doing hospital work. Some of us plan eventually to become R.N.s. Others are uninformed about the opportunities in male nursing and about how to get into it.

Why doesn't the A.N.A., the National League for Nursing, or some hospital school contact us? We've already had some formal instruction and considerable bedside experience.

Richard H. Falk
U.S. Naval Air Station
Atlantic City, N.J.

ROUTINE'S A TEACHER

DEAR EDITOR: Repetitive bed-making as a "must" for students is exploiting them, says Maxime Taylor in your news columns.

But is it?

While doing this routine work,

the student has the opportunity
observe her patients; and of su
observation she can never ha
enough.

The modern student needs *mo*
close association with patients.

R.N., Wiscons

THE PAY DOESN'T PAY

DEAR EDITOR: Why don't retir
nurses return to active duty? M
own case—typical of many—a
swers that question conclusively

The nearest hospitals are twe
ty-eight miles from my home. Sa
ary offered is about $240 a mont
After paying my car costs, I'd n
about 73 cents an hour for m
time away from home.

A small chiropractic hospit
five miles from home pays $1
hour and gives one meal a day.

Figure it out: Which is better?

R.N., Pennsylvan

NO SEXY UNIFORMS!

DEAR EDITOR: If a nurse's unifor
is neat, clean, and functional, suc
matters as color and material a
secondary. The wearer's objecti
is what counts.

The starchiest white unifor
ever created never made a nur
out of a woman—no matter ho
thorough her scholastic training.

Sybil E. Watson, R.
Philadelphia, Pa.

DEAR EDITOR: After viewing th
new trend in uniforms, as illustra
ed in *RN*, I'm disappointed.

How can a nurse possibly loo

In summer, too,

YOU
AN TURN OFF
THE COUGH
NTIL MORNING

TUSSIONEX™

A 'Strasionic' Release Product • Dihydrocodeinone Resin—Phenyltoloxamine Resin

8-12 Hour Control with a Single Dose

Suppresses nighttime sleep-robbing, daytime distracting, useless coughs without interfering with the protective cough mechanism.

Over 12,000 clinical observations [1, 2, 3, 4] demonstrate its wide field of usefulness in ages ranging from 3 months to more than 70 years.

Supplied in Two Forms:

Each teaspoon (5cc) Tussionex liquid or Tussionex tablet contains 5 mg. dihydrocodeinone and 10 mg. phenyltoloxamine as resin complexes. Stock bottles of 16 oz. or 100 tablets.

Suggested Dose:

One teaspoon (5cc) or one tablet every 8-12 hours. May safely be adjusted to meet individual requirements.

Rx only • Class B taxable narcotic

References

(1) Chan, Y. T. and Hays, E. E., The American Journal of the Medical Sciences, August 1957; (2) Townsend, E. H. Jr., The New England Journal of Medicine, January 9, 1958; (3) Weismiller, F., In Press; (4) Cass, Leo J. and Frederik, W. S., In Press.

STRASENBURGH

Originators of 'Strasionic' (sustained ionic) Release

R. J. STRASENBURGH CO., ROCHESTER, N. Y., U.S.A.

professional in "a striking, long-sleeve sheath with plunging neckline and stand-up collar"? (This would be a gem in "shocking pink"!)

I've been a graduate for only three years. Yet I strongly advocate the once-popular starched white cotton uniform with long sleeves and high neck.

I prefer to look and feel like a nurse—not like a sexy chorus girl!

Carol Ann Zeidler, R.N.
New Rochelle, N.Y.

TWO-YEAR R.N.s

DEAR EDITOR: The two-year graduate sounds (as your April article indicates) like a good idea. But you're wrong if you think that the hospitals—and the two-year graduates themselves—will adhere to the principle that such graduates aren't intended to be charge nurses.

Take the practical nurse as a straw in the wind. She's been given responsibilities far beyond her training.

Your two-year R.N. will also be allowed to "take over."

As far as I'm concerned, we're not improving our nursing standards; we're simply lowering them. I, for one, want our profession to put its emphasis on quality rather than on quantity.

R.N., Illinois

END

Pfizer *drug notes*

COMBIOTIC®

combined penicillin and dihydrostreptomycin therapy

Combined antibiotics in one vial means only one injection. Prescribed for its potent attack on mixed bacterial infections; for surgical infections or prophylaxis; for a variety of common infections. When high dosages are given for long periods, watch patients closely for dizziness, tinnitus, allergic reactions.

COMBIOTIC P-S (DRY POWDER) 1.0 GM. FORMULA: 300,000 units penicillin G procaine crystalline; 100,000 units penicillin G potassium crystalline; 1.0 Gm. dihydrostreptomycin sulfate per dose. 0.5 GM. FORMULA: same penicillin content as above but with 0.5 Gm. dihydrostreptomycin sulfate per dose. COMBIOTIC AQUEOUS SUSPENSION (ready to inject) in five-dose "drain-clear" (10 cc.) vials, 400,000 units penicillin G procaine crystalline and 0.5 Gm. dihydrostreptomycin sulfate in each 2 cc. dose. Also available in:

one-dose cartridge with needle

STERAJECT®

sterile needle—disposable cartridge assembly cuts down nursing time and work of I.M. injections.

Unbreakable Steraject syringe (re-usable without sterilization) holds individual dose of antibiotic in Steraject cartridge. The cartridge is supplied with sterile needle attached. Simply insert into Steraject syringe, inject, dispose of cartridge and needle. Prevents cross infection; saves precious nursing time. Pfizer injectables available in single-dose disposable cartridges:

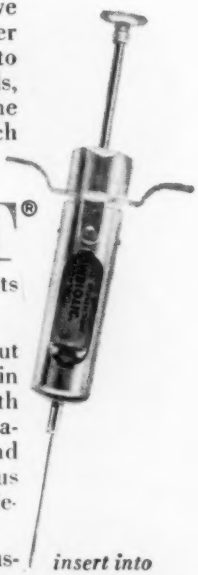
Penicillin G Procaine Crystalline in Aqueous Suspension, 300,000; 600,000 and 1,000,000 units.

Combiotic Aqueous Suspension, 400,000 units penicillin G procaine crystalline plus 0.5 Gm. dihydrostreptomycin.

Streptomycin Sulfate Solution, 1 Gm.

Dihydrostreptomycin Sulfate Solution, 1 Gm.

(most with 22-gauge needle to minimize injection pain).



insert into Steraject syringe— remove sheath— ready to use!

PFIZER LABORATORIES, *Division, Chas. Pfizer & Co., Inc.*, Brooklyn 6, N. Y.

Dial proved more effective against skin bacteria than any other soap

Former Hexachlorophene Dial.

New Dial with TCC and a chlorinated bisphenol.

Bithionol Soap.

TMTD Soap.

The same ingredient in Dial that destroys odor-causing bacteria also sweeps away bacteria that often cause skin blemishes.

You now can prescribe one soap—Dial—to aid in counteracting both skin odor and skin blemish conditions.

Dial's new *synergistic* combination of *two* deodorant ingredients—a chlorinated bisphenol *and* a trichlorocarbanilide, shows a marked superiority in all tests.

Dial inhibits the growth of a wider range of skin bacteria (both gram-positive and gram-negative) than any other soap now available.

In vitro tests prove Dial's superiority

These culture plates were streaked with the organism M. *pyogenes* var. *aureus* (bacteria causing odor and pyogenic trouble). Then 5 p.p.m. of the test soap were added to each plate.

Dial is also available in guest sizes for hospitals. Ask your hospital purchasing agent to write our laboratory at the address below for information or free trial samples.

FROM THE SOAP DIVISION OF ARMOUR AND COMPANY • 1355 W. 31ST ST., CHICAGO 9, ILL.

RED CROSS
IMPROVED BANDAGE

conforming gauze
makes your bandaging easier!

just rolls on ...

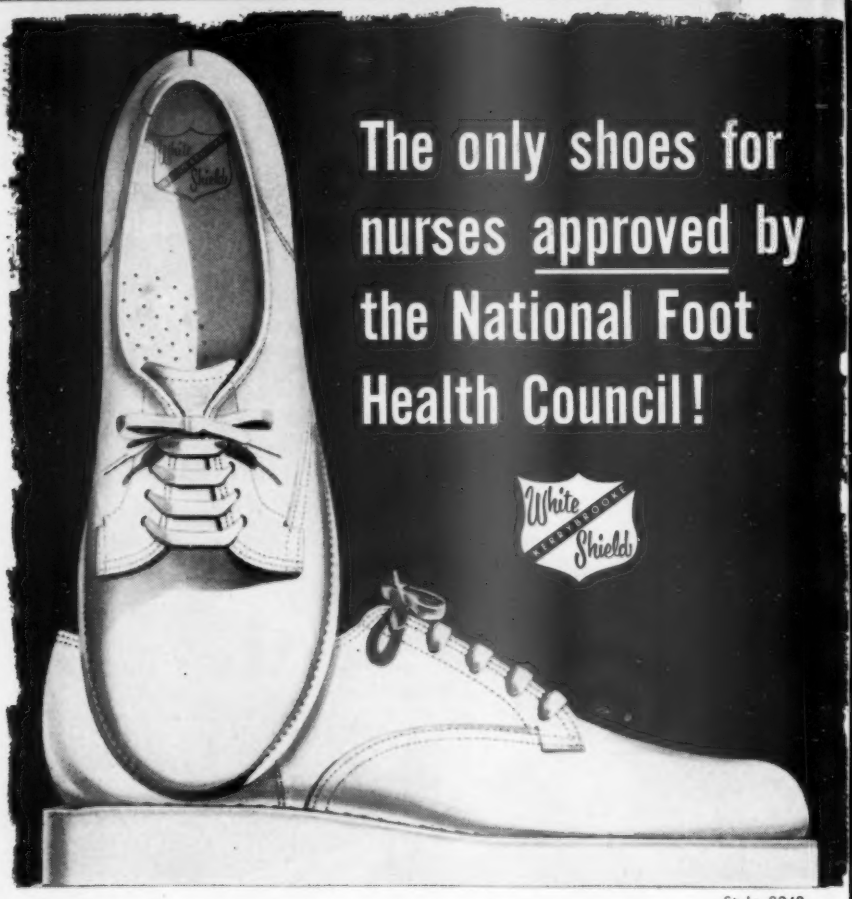
NFORMS
ıny shape.

ADHERES TO ITSELF
—will not slip or slide.

STRETCHES
—will not constrict
swelling area.

THE OLD WAY. Ordi-
ıary gauze bandage
oosens up and frays
ıt edges, and re-
stricts movement of
oints.

THE NEW WAY. New Red Cross Improved Bandage stays on smoothly . . . allows more freedom of movement.



Style 2940

SMART STYLE . . . CORRECT FIT . . . EXCLUSIVE WITH SEARS

Kerrybrooke White Shield Shoes are the only shoes for Nurses that meet the high standards of exacting fit and correct comfort established by the National Foot Health Council.

Made of top quality washable leather that cleans beautifully. Cushioned beneath your arch to reduce fatigue. Lightweight, flexible, long-wearing soles. There are three easy ways to buy them: at Sears Retail Stores, by mail or phone from the new Fall catalog, or at your nearest Sears Catalog Sales Office. **Only $7.98**

Style 2937

Style 2938

Sold only at Sears . . . Satisfaction guaranteed or your money back

RN news

BRITISH M.D.s URGED TO LIGHTEN NURSES' WORK

Let TPRs be taken only when a clinician specifically asks for such readings. And let lay clerks handle as much hospital paper work as possible.

So suggests Britain's medical journal, The Lancet, reminding hospital physicians that ward nurses are needed increasingly for techniques that are a lot more important than routine TPRs.

Such readings are of questionable value anyway when taken routinely, the journal contends; and the time consumed by them could be far better spent on patient care.

A.N.A.'s NEW PIN, official black-and-gold symbol of membership in the organization, goes on sale at this month's biennial convention in Atlantic City. It may be ordered thereafter from the various state nurses' associations.

NURSE WINS $56,000 IN HOSPITAL SWEEPSTAKES

The voice on the phone was one she'd never heard before. And the news sounded so preposterous that Alice Murphy felt sure it was a prankster calling.

It wasn't. The reporter on the line was a bona fide newspaperman. But it took a bit of doing on his part to convince the young nurse that she'd just won $56,000 on a horse named Tiberetta.

Miss Murphy's father, it seems, had bought a ticket in her name on an entry in the Irish Hospital Sweepstakes. "I've never played the horses myself," says the 23-year-old R.N.

She'll net, she figures, about $23,000 after Uncle Sam claims his share in income taxes. And she

Alice Murphy, R.N.

plans to divide that sum with her dad.

Part of what she keeps for herself will go, she says, toward com-

pleting her studies for a degree. And some may be spent on a trip to Europe this summer.

Meanwhile, she's continuing to do general duty at St. Joseph's Hospital in Paterson, N. J. She went right back to work the night after the day it all happened.

3 (OR 4) POLIO SHOTS?

If two polio shots give 75 to 80 per cent immunity and a third shot raises the figure to 90 per cent, then a fourth one should afford even greater protection.

So reasons Dr. Lewis L. Coriell of the University of Pennsylvania.

Experience, he points out, has shown that in some youngsters paralytic polio crops up even after a third injection. One more shot might prevent this, he believes.

A somewhat different viewpoint is found in a report of the National Advisory Committee on Poliomyelitis. The committee recommends that a fourth shot be considered only where circumstances warrant it—for example, in epidemic-threatened areas or among persons entering a high-incidence locality.

For the vast majority, the committee finds, three shots suffice to provide immunity for three to four years. A fourth shot, it adds, should be given only when a physician advises it.

N.A.C.P.'s membership included Dr. Julian Price of the A.M.A.'s Committee on Poliomyelitis.

AWARD WINNER: Sister Paschala Noonan, O.P., maternity supervisor at St. Catherine of Sienna Hospital, McCook, Neb., is the 1958 winner of the Mary M. Roberts Fellowship. This annual award of the American Journal of Nursing Company is given to a promising writer for a year's study in the field of journalism.

HEART GROUP ANNOUNCES 'BIG NEWS'—TOO SOON

Newspapers front-paged the announcement. It came, after all, from an unimpeachable source, the Massachusetts Heart Association. What's more, it concerned the discovery of a clot-fighting mold extract—one that promised quick relief in heart attacks. So the news seemed as significant to some as the discovery of penicillin. MORE

o need to drydock "swimming ear"

In "swimming ear" and other forms of Otitis Externa, Biomydrin Otic gives fast relief from pain, swelling and itching. And where there is a history of recurrence of "swimming ear," Biomydrin Otic has a prophylactic action if used before and after swimming. Biomydrin Otic is also effective as adjunctive medication in Otitis Media, supporting the systemic therapy of your choice. Ingredients: *topically anesthetic* thonzylamine HCl, *anti-inflammatory* hydrocortisone, *anti-bacterial* neomycin and gramicidin, and *mucolytic* thonzonium bromide. Self-sterilizing, in ½ oz. plastic bottle that delivers one drop at a time.

For otitis externa and otitis media

BIOMYDRIN® OTIC

WARNER-CHILCOTT

But subsequent word indicates that the M.H.A. promised more than it could deliver—at least at present.

Asked by *RN* for further facts about the new extract, its discoverer, Dr. Mario Stefanini of Boston's St. Elizabeth's Hospital, said he felt the news had been released prematurely. "We need further evaluation before any definite conclusion may be reached," he declared.

POLICE AND SCIENTISTS were still baffled at last report by The Case of the Jumping Household Objects—the widely publicized phenomenon connected with the Seaford (N.Y.) "mystery house" occupied by Nurse Lucille Hermann and her family. The case remains, as one newspaper phrases it, "a whodunit without a crime, a criminal, or a solution."

TUITION CUT: The University of Michigan's one-year course in anesthesia is now $90 (instead of $135) for Michigan R.N.s, $170 (instead of $310) for out-of-state nurses. The reduced fees, it's hoped, will help relieve the nationwide shortage of nurse-anesthetists.

YALE UNIVERSITY announces the appointment of Florence S. Schorske as acting dean of its school of nursing. She replaces

Dean Elizabeth S. Bixler, whose retirement this month follows her recent marriage to Professor Norman L. Torrey of Columbia University.

CANCER GETS SPOTLIGHT AT CLINICAL CONGRESS

Colonic cancer—a killer that takes 2,500 lives a month—generally gives such ample warning that its onset can be averted by a simple office procedure, says Dr. Neil W. Woodward Sr. of the University of Oklahoma.

The procedure? Removal of colonic polyps that usually precede the malignancies. In most cases, says the surgeon, the polyps can be found by visual examination—and at least 10 per cent of people over 40 harbor them.

Dr. Woodward's findings were reported at a recent congress of the International College of Surgeons. Other highlights of the meeting:

¶ Dr. Alfred A. Strauss of Chicago's Michael Reese Hospital reports success in coagulating cancers with electric-needle therapy. In a sample of 350 patients many of them over 60, half so treated have survived ten years, he states. A coagulated cancer, he believes, can act as an immunizing antigen against metastasis.

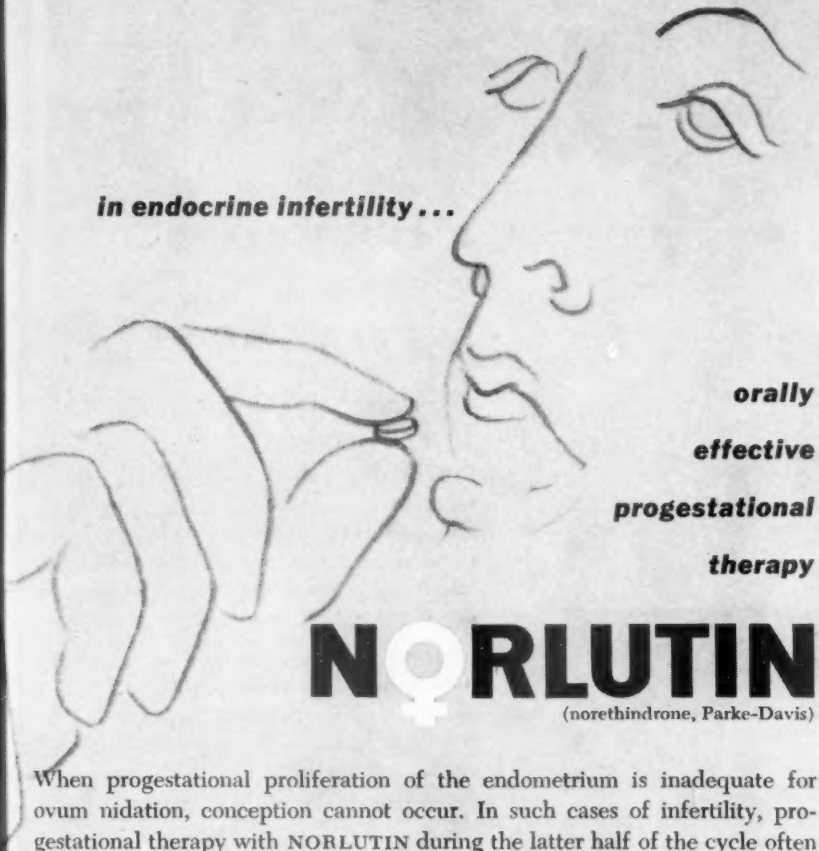
¶ Dr. Seiichi Makuuchi of Tokyo's Red Cross Central Hospital

reports replacement of a cancerous urinary bladder with an artificial one constructed from an isolated segment of the intestine. Two of five patients who have undergone such surgery are experiencing satisfactory use of their new bladders, he states.

¶ Dr. Louis T. Palumbo of the Veterans Administration advocates complete removal of the sensory and motor pathways to and from the heart as a treatment for angina pectoris. The operation, he says, "insures complete or nearly complete relief from disabling pain" and in no way impairs the patient. Rehabilitation is rapid, and many patients are returned to near-normal life, he adds.

¶ Weeping eczema of the resistant type can be treated successfully with a heparin-antibiotic combination, says Dr. David A. Dolowitz of Salt Lake City. In twelve cases, he reports, all responded rapidly to a preparation of 1 per cent heparin combined with either 3 per cent neomycin, 3 per cent polymixin, or 3 per cent streptomycin.

¶ Bacteria affecting the respiratory tract are killed quickly and prevented from developing drug-resistant strains if detergents are added to antibiotics and used as inhalants, states Dr. Edwin J. Grace of New York City. The combination may also be helpful as an injection into the marrow in the treatment of osteomyelitis, he believes. END



in endocrine infertility . . .

orally

effective

progestational

therapy

NORLUTIN™

(norethindrone, Parke-Davis)

When progestational proliferation of the endometrium is inadequate for ovum nidation, conception cannot occur. In such cases of infertility, progestational therapy with NORLUTIN during the latter half of the cycle often produces clinically desirable results. Through endometrial improvement the possibility of conception is greatly enhanced.

CASE STUDIES*

NORLUTIN or a congener was given to 50 infertile patients daily from the fifth to the twenty-fifth day of their cycles. Within five months of their last treated cycles, seven women conceived. While two of these had secondary infertility . . . five had been inexplicably barren for from three to six years.

INDICATIONS FOR NORLUTIN

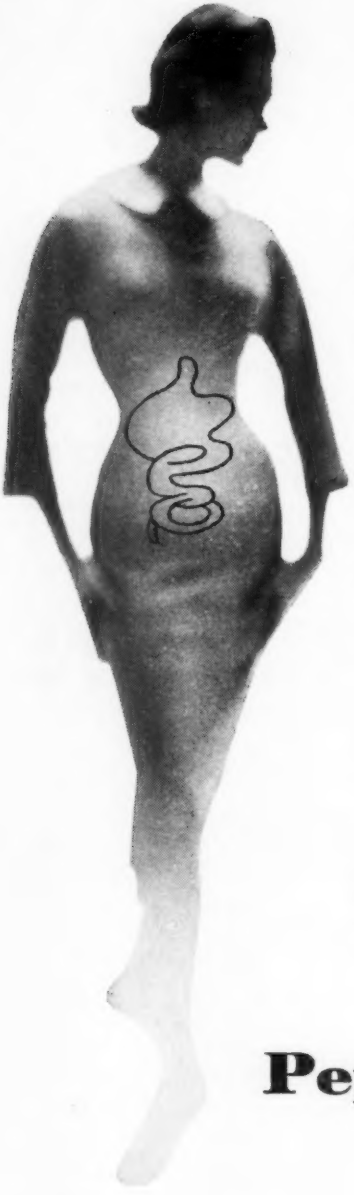
conditions involving deficiency of progesterone such as primary and secondary amenorrhea, menstrual irregularity, functional uterine bleeding, endocrine infertility, habitual abortion, threatened abortion, premenstrual tension, and dysmenorrhea.

PACKAGING: 5-mg. scored tablets (C. T. No. 882), bottles of 30.

*Rock, J.; Pincus, G., & Garcia, C. R.: *Science* 124:891 (Nov. 2) 1956.

PARKE, DAVIS & COMPANY · DETROIT 32, MICHIGAN

34094



CONTROL UPSET STOMACH

—without interfering with peptic digestion

For indigestion or nausea, Pepto-Bismol is superior to alkalizers and antacids in many important ways. Its unique coating action helps the stomach return to normal without interfering with digestive acids and enzymes and without "acid rebound."

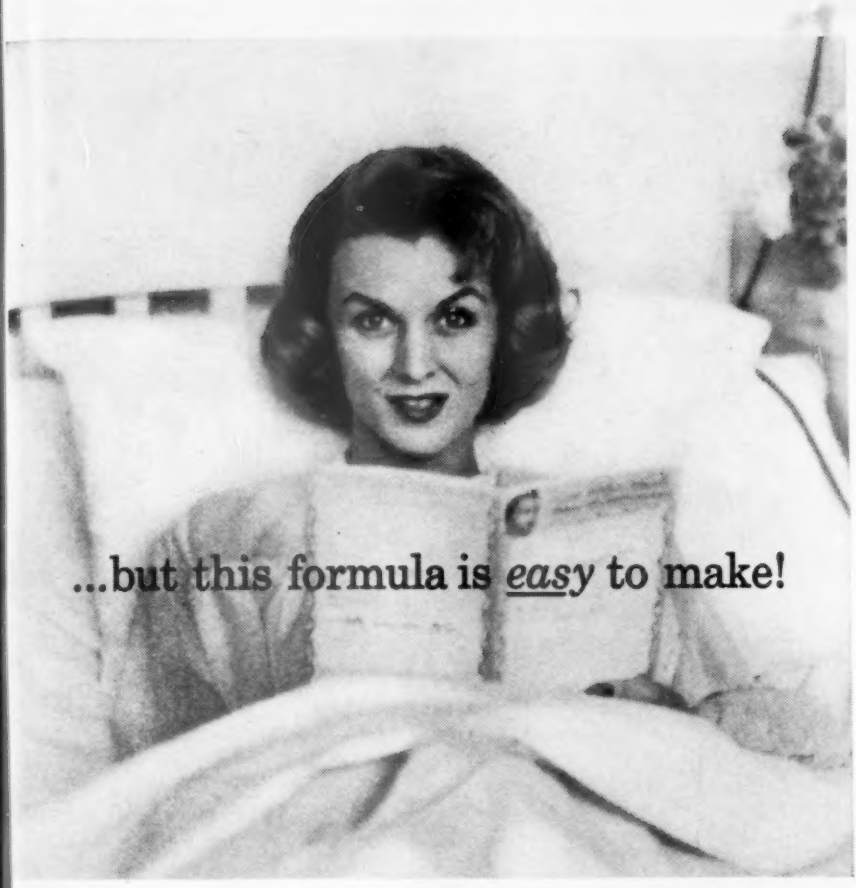
Controls diarrhea, without subsequent constipation. Unlike paregoric and other opiate preparations which are often constipating, Pepto-Bismol's demulcent coating action helps control simple diarrhea and allows bowel function to return to normal, usually within 24 hours.

Because Pepto-Bismol is so wonderfully gentle and effective throughout the stomach and intestinal tract, it has been used and recommended by practicing physicians and nurses for almost fifty years.

Pepto-Bismol®

Active ingredients: Bismuth Subsalicylate, Salol, Zinc Phenol-sulphonate and Methyl Salicylate Synthetic in a demulcent base.
Note: The beneficial medication in Pepto-Bismol may cause a temporary darkening of the stool.

ANOTHER FINE Norwich® PRODUCT



New mothers sometimes think preparing an evaporated milk formula is more complicated than proprietary formulas.

Actually, since sterilization is the same, the *only* difference is that the mother adds the carbohydrate...the specific type and amount *prescribed by the physician* as best for her baby.

This gives the infant the advantages of his own evaporated milk *prescription* formula, readily adjustable to meet his changing nutritional needs – a *flexibility* not possible with proprietary formulas.

The mother who knows this will not consider adding the carbohydrate any "trouble" at all!

Carnation

"FROM CONTENTED COWS"

Optimum prescription-quality in today's trend to the individualized formula.

RN literature and samples

PAPER DISPOSABLE CONTAINERS: A portfolio of literature describes an interesting variety of containers, for use in the hospital laboratory, operating room, cafeteria, or patient bed services. SEALRIGHT CO. **G-1**

PLASTIC SURGICAL DRESSING: Aeroplast is a plastic protective spray, yellow-tinted, which can be used as a primary or secondary surgical dressing. Aeroplast conforms to any body contour, is waterproof, and permits the skin to "breathe." Literature is offered by AEROPLAST CORP. **G-2**

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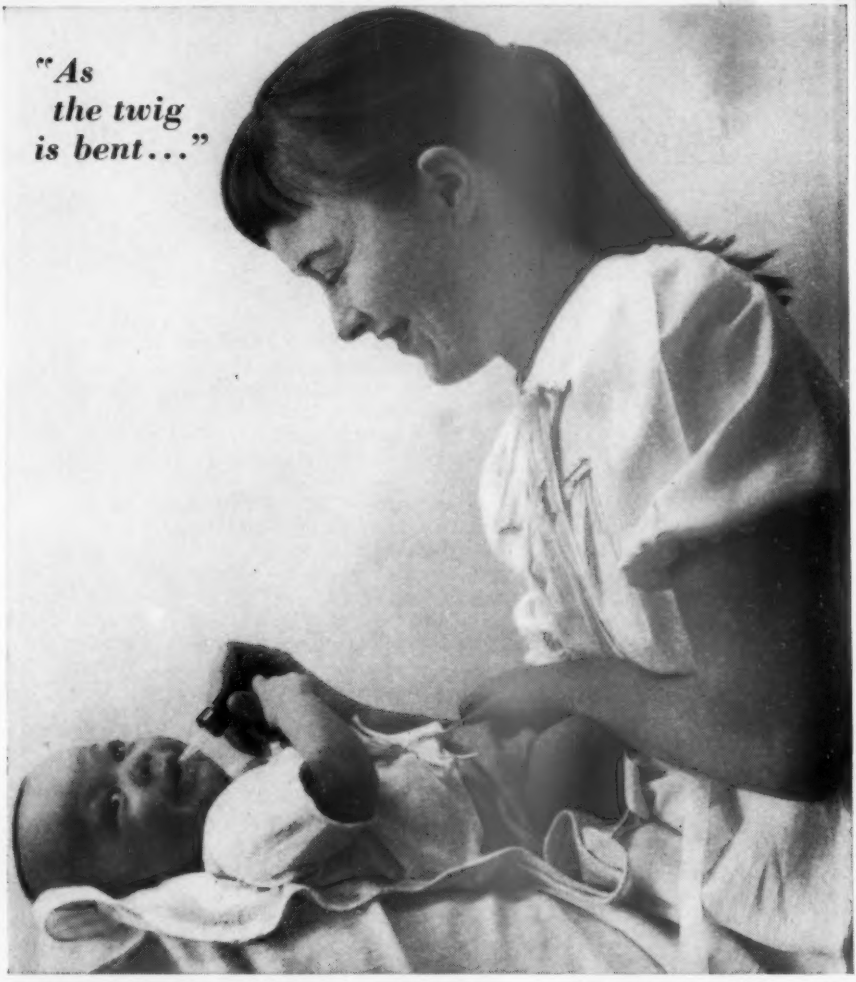

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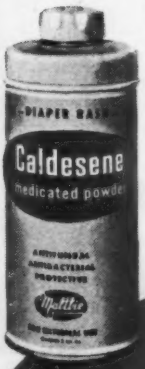

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RN

'Back to the Bedside!'

Does this cry reflect a real urge among R.N.s to give more bedside care? Or merely a desire to escape new responsibilities?

By Mary MacRostie, R.N.

Keep your ears open in the hospital locker room or wherever nurses talk shop. Over and over you'll hear the words: "I want to give patient care but I'm bogged down with too much desk work."

It's true that each year professional nurses have less contact with patients than the year before.

How little it amounts to today may surprise you. Dr. Faye Abdellah of the U.S. Public Health Service found from a study of fifty-four hospitals that "the professional staff nurse spends only eighteen minutes

RN will be glad to consider publishing YOUR *comments on this frankly controversial issue.*

during an eight-hour shift with each patient."

So there's reason for all the talk you hear.

But do nurses *really* want to give more patient care? Or is this back-to-the-bedside cry only a sign of resentment toward their increased responsibilities?

Do they envy their aides' chance to give bedside care? Do they feel that their traditional role has been taken over by less qualified people? Is a close nurse-patient relationship really important for R.N.s?

To assay opinion on these questions, I queried staff nurses and nursing educators in seventeen states.

Consensus of Nurses

Most of the general and private duty nurses who gave me their views said they *want* to give patient care. "Why, that's what I was trained for," was a typical reply.

On the other hand, almost all the directors of nursing and the teachers I questioned thought we should go along with the newer concept—"nursing by remote control," as one phrased it.

An Illinois R.N. who insists on doing only private duty says, "I gave up general duty a year ago. I simply couldn't go along with the new theories of 'long-distance' nursing. Here's why:

"I was still doing general floor duty when a woman described as a 'very capable aide' was assigned to my unit. One of her first charges was a patient who'd just had a hernia operation and was getting nasal oxygen plus suction.

"My 'capable aide' decided to change the patient's position, so she detached the nasal tube from the oxygen tank and the Levin tube from the suction machine. Then, after she had turned the patient, she mistakenly attached the oxygen-tank tube to the Levin tube.

"The patient died within minutes. A massive GI hemorrhage had been caused by the force of the oxygen flowing into her stomach.

"Right then and there I said 'No thanks. I belong at the patient's bedside. Never again will I let myself be chained to a desk!' "

Janet Geister, for many years a contributor to *RN*, reinforces this nurse's view when she says: "Many of us are bitter over separation from patients, particu-

larly since a number of our most sacred duties have been given to others—some of whom are grossly unprepared."

Claire Garron, a general duty nurse in Philadelphia, cites what she feels is an equally serious problem: "Nursing's public relations," she says, "are damaged more and more as patients leave our hospitals saying, 'The only time I ever saw an R.N. was when I needed medication!' "

A Southern private duty nurse thinks the pressure of desk work on nurses will eventually ease because the newer concepts of nursing just aren't workable. Says Corinna Lewis of Largo, Fla., "It's just a matter of time before hospital administrators realize that the nurse at the bedside is a must."

A well-known Western educator agrees: "Nurses are trained for bedside nursing. They're unhappy with all this desk work and red tape. An R.N. doesn't want a team of eight subordinates between her and her patient."

It's apparent from these opinions that many nurses think desk work and supervision of aides take the real meaning out of their careers. Yet others feel just as strongly that the days of the close nurse-patient relationship are over—that nurses must go with the tide. Says Marjorie Glaser, vice president of the Kentucky State Nurses Association:

"Most of us became nurses because we wanted the satisfaction and gratification of helping sick people get well. I know it's hard, very hard, to give up this pleasure; but we must accept the fact that we have been upgraded. I don't mean to imply that there's no place for bedside nursing. Sometimes a patient needs the highly skilled care that only a private duty nurse can give.

"However, on the whole, modern nursing isn't a 'do-it-yourself' profession any more. It's a profession that directs and teaches. If we adapt ourselves to the newer concept and try to find satisfaction in our administrative functions, we'll help our patients far more than we do by griping."

The role of the nurse as administrator is stoutly defended also by the dean of Seattle University's School of Nursing:

"Bedside nursing is not the *only* type of nursing," says Sister Mary Ruth. "Sometimes those of us in hospitals forget this. Nurses who stress bedside care to the exclusion of all other types and

who reject their administrative and teaching functions are simply trying to escape their new responsibilities.

"I have to smile when I hear nurses say they can't spend enough time with the patients because of desk work and supervision of aides. Most of them have forgotten that they never *did* stay with their patients *all* the time.

"A few years ago they were bogged down in housekeeping details such as folding linen, shining faucets, and scrubbing bathtubs. Frankly, I'd rather be working at a desk than cleaning a utility room. And I don't think patients are now receiving poor care—not, at least, in hospitals where the general duty nurses closely supervise their aides."

'Not Cut Out for It'

Head nurse Bernice Neff of Downey, Calif., says, "I like to think I'm a good R.N. But I wasn't cut out to be a bedside nurse. I get satisfaction, instead, out of the smooth running of my ward; and I like to teach aides to give good care. Some R.N.s waste far too much time mourning the days when they used to do it all!"

Some R.N.s questioned think that nurses give only lip service to the idea of wanting to work at the bedside. According to the director of nursing education at a well-known Eastern medical center, "Nurses *say* they want to give patient care; but it's just talk. Here's how I found out they don't mean what they say:

"Recently, our floors were overstaffed, so each nurse was assigned to three bed patients. None of the nurses complained, but their attitudes showed that this wasn't what they really wanted.

"I've had similar experience with college nursing students," she continues. "It was like pulling teeth to get them to give bedside care. In a recent class of thirty such college-level nurses who graduated from a well-known university, not *one* chose bedside nursing as a career."

So, for the present at least, there are two camps within the profession: One says the nurse belongs at the bedside; the other thinks she should be an administrator, leader, and teacher of auxiliaries.

It will take time to answer the question: Where does the nurse belong? But the answer is com-

ing. Experiments with intensive-care units for critically ill patients are gaining in popularity.

Says Dr. Abdellah, "The thing that impresses me most about these intensive-care units is the waiting list of professional nurses who want to get on their staffs."

As intensive-care units increase in number, the need for bedside nursing will give a chance to those who now decry the lack of it. And the alternative—wards for the ambulatory and the not so critically ill—will be tailor-made for the R.N. who wants to administer and supervise.

Meanwhile, nursing leaders suggest, let's try to be patient-centered rather than self-centered in our attitude toward bedside care. END

"No, No! That's when *they* come to visit *us*."

Resuscitation for Cardiac Arrest

You may help save a life if you're prepared to assist in this emergency technique

By Eileen McGloin, R.N.

"Well, that's it. His heart has stopped. Let's go take care of the living."

How many times have you heard doctors say that? Some patient of yours with an apparently normal heart suddenly stops breathing. You put your fingers on his wrist, then on the carotid artery, but there's no pulse.

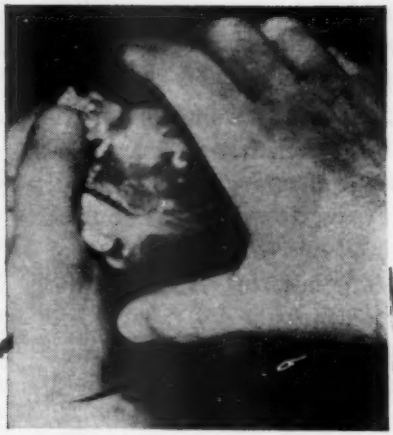
You call the doctor. Maybe he tries artificial respiration. Maybe he injects adrenalin into the heart. But your patient fails to respond.

Until very recently, medicine more or less accepted the idea that once the heart stops life is over. But largely through the efforts of one man, Dr. Claude S. Beck of University Hospitals in Cleveland, this attitude is now changing.

"Every normal heart can be made to beat again," says Dr. Beck. "We just have to give it another chance."

The "miracle" of cardiac resuscitation has been routine in operating rooms for many years. Surgeon, anesthetist, and scrub nurse are a trained team. They know how to treat cardiac arrest

ASIC SET-UP: With a scalpel and chest retractor, two people—one do mouth-to-mouth breathing and ne to massage the heart—can keep patient alive.



CARDIAC MASSAGE is a rapid, pumping action. Thumb and fingers are brought together to empty the ventricles, then they are spread wide apart to let them fill.

nd have on hand everything eeded to do it.

But Dr. Beck and his associ-tes, in a monthly workshop ponsored by Cleveland's heart ociety, are showing that the OR am is not the only group cap-ble of treating cardiac arrest. n the ward, in the out-patient epartment, in the doctor's off-e, any group can become a

REATHING FOR THE PATIENT is ade easy with this portable resusci-tor. The cylinder between the bag nd the face mask contains a one-our supply of oxygen. A small soda-me filter absorbs exhaled CO_2.

skilled team, ready to meet and overcome the crisis of cardiac arrest.

To find out how Dr. Beck teaches this skill and preparedness, *RN* sent me to Western Reserve University in Cleveland. Doctors, dentists, and nurses from all over the world go there to learn how to resuscitate the arrested heart.

The workshop I attended was held on two consecutive days. The first day we heard lectures on the etiology and management of cardiac arrest, and we watched a surgical team perform the technique on anesthetized dogs. The second day everyone was given the opportunity to practice the technique himself.

The first things demonstrated were how a normal heart can stop beating and how it can be started again.

Suppose that for some reason (sensitivity to or overdosage with anesthesia or drugs, inadequate oxygen supply to the heart muscle, carbon-dioxide retention, or other factors related to anoxia) the conductive mechanism that

DEFIBRILLATION is achieved by placing an electrode on either side of the heart, squeezing them firmly together as a one-second shock is applied. Note that the operator holds the electrodes by their insulated handles to protect herself from the current.

controls the heartbeat is interrupted. The heart then either comes to a complete standstill or goes into a state of useless ventricular fibrillation. At that point the victim is, to all intents, dead.

Speed Is Essential

If *within three minutes* his oxygen system can be re-established (oxygen delivered to his lungs by mechanical respiration and oxygenated blood to his brain by cardiac massage), he will most likely survive.

If more than three minutes elapse, he *may* survive. He may also have permanent brain damage. For when the heart stops, the brain is the first organ to respond to the loss of its oxygen supply. And the longest the brain can live without oxygen is about five minutes. After that the higher centers die, and restoring the oxygen system may bring back to life only a decerebrate human being, a "vegetable." More often, death due to severe brain damage follows in a few days.

To avoid this tragedy, the medical team has to be so well prepared to meet the crisis of cardiac arrest that it can do the job almost automatically.

When ventricular fibrillation occurs, oxygenation and cardiac massage are still the first requirements, just as they are in a case of cardiac standstill. They will serve the purpose of keeping the patient alive and preventing brain damage.

But alone they can never stop fibrillation or restore a normal heart beat. This can be done only by "defibrillating" the heart—applying a strong electric shock directly to the heart muscle.

The heart will then either begin to beat regularly on its own or come to a stop. If it stops, it can be massaged again to make it start beating by itself.

These principles were all vividly displayed at the laboratory in Cleveland. We gathered around the table for the first demonstration. An anesthetized dog was given a weak electric shock that caused immediate cardiac arrest by ventricular fibrillation.

The oscilloscope, picking up the pattern of the heart's action from an electrocardiogram, and tracing it on a bright blue screen, showed what was happening. Before the shock there was a normal pattern. After it, the wild, exaggerated peaks and valleys of ventricular fibrillation. MORE ▶

In a matter of seconds Dr. David Leighninger turned the dog on its side, made a wide, sweeping incision across its left chest, thrust his hand into the cavity, and began to massage the heart. Simultaneously the anesthetist inserted a laryngoscope into the animal's mouth, passed an endotracheal tube through it into the trachea, and attached the tube to the oxygen-filled breathing bag of a mechanical respirator.

As soon as the doctor began to massage the dog's heart, the oscilloscope showed the normal pattern produced by the rhythmic pumping action of his hand, and the blue, fibrillating organ began to grow pink. But when he took his hand away for an instant, there was the wild, exaggerated pattern again. Oxygenated blood was being circulated throughout the dog's body. But his heart was still fibrillating.

Defibrillation

Then the doctor held out one hand. (He continued to massage with the other.) His assistant placed one of the electrodes of the defibrillator in the outstretched hand. Rapidly, the doctor placed the electrode under the dog's heart, then stopped massaging, took the other electrode and placed it on top of the heart. He squeezed the electrodes firmly together and the assistant released the current. An electric shock of two amperes passed through the fibrillating heart.

Normal Again

Dr. Leighninger removed the electrodes and stepped back. We pressed closer and peered over his shoulders. Gone were the chaotic movements. The dog's heart was beating quietly with the coordinated, rhythmic contractions of a normal heart. And the oscilloscope again showed the pattern of a normal electrocardiogram.

The technique of resuscitation was repeated on a second dog. This time, cardiac standstill was demonstrated. But resuscitation was purposely delayed beyond the safe (three-minute) time limit between arrest and the start of oxygenation and massage.

The dog's chest was opened first, under general anesthesia. (This was done so we could see clearly what happens to the heart and lungs when cardiac arrest occurs.) Then he was asphyxiated. This was accomplished by

the simple expedient of turning off the respirator that had been breathing for him.

When the incision was made, the heart was visible through the opening in the chest. It was bright red and lustrous and beating smoothly. It rose up and down on what looked like a cushion of bright pink foam. These were the lungs, expanding and contracting as the respirator inflated and deflated them.

Cardiac Standstill

Then the respirator was stopped. The lungs collapsed, sinking down into the chest and quickly turning dark red. They seemed to shrink until they assumed the color and appearance of liver.

For a few minutes the heart continued to beat—faster and faster, trying vainly to speed the circulating blood and to keep enough oxygen flowing to the vital organs. But soon the last bit of oxygen was used up and the heart gradually became distended, blue, and lustreless. Finally it stopped.

After about five minutes, resuscitation was begun. The mechanical respirator pushed oxygen into the lungs, and Dr. Leighninger started to massage the heart. Seconds later, the dog's lungs began to expand and to resume their normal appearance. The heart regained its normal color.

But this second dog took longer to resuscitate than the first one. It also had to have 2 ml. of 1:10,000 solution of adrenalin injected into the right ventricle (plus immediate massage to distribute the adrenalin throughout the myocardium) to help overcome muscle atony.

Too Late!

Next day both dogs were brought into the lecture room. The first one walked around sniffing at the strangers, his tail wagging happily. The second one crouched where he had been put, listless and inactive. His brain had been damaged, perhaps permanently, by prolonged lack of oxygen.

Over and over again, both verbally and in demonstrations, the Beck group repeated its evidence that the only things immediately necessary in emergency cardiac resuscitation are speed, breathing for the patient, and hand-pumping his heart. Everything else can wait. [MORE ON 85]

She Stars

Jane Warren swaps views on child care with comedy star Victor Borge on one of her TV shows.

"Hi, Mom!" is the show. It's televised daily on Channel 4, New York.

Jane Warren is the star. She's a pediatric nurse who builds her program around baby-care demonstrations, interviews with parents and others, and answers to questions from her millions of viewers.

Jane is something rare on TV —not an actress playing a part, but a professional doing the job for which she was trained. Slender, dark-haired, and attractive, without any touch of phony "glamour," she radiates an aura of unaffected, wholesome competence.

"Being a TV star is fun," says Jane. "I love it. But if someone

on Television

By Roberta Michaels, R.N.

were to walk up to me right now and say, 'Jane Warren, you can't be a nurse and appear on television too,' I'd quit television. I've been a nurse too long to give it up for anything else."

Jane became an R.N. in 1948 after training at Hinsdale Hospital School of Nursing in Illinois. She took postgraduate courses at Children's Hospital in Detroit and later studied polio nursing at Children's Memorial in Boston. Ironically, Jane herself contracted polio in 1951.

"I recovered almost completely," she says, "and for that I'm more grateful than I could ever tell you. My legs get a bit tired now and then. But otherwise I'd never know I had polio."

After her recovery, Jane became a head nurse at a Chicago hospital. It was there, strangely enough, that television "found" her.

"One day," as she tells the story, "a woman was brought in with a fractured ankle. After the doctor put a cast on it, we took her to her room. It was crowded with visitors. I started to shoo some of them out. One, a young man, said something about making a television star out of me. I laughed and kept right on showing him the door."

The young man actually *was* a TV producer, though. And he knew a photogenic R.N. when he saw one. So he kept after Jane and eventually signed her up for

a series of fifteen-minute teaching films called "It's Baby Time."

"That's how I got on TV," says Jane. "A sponsor bought the film series, and now it's been incorporated into the daily one-hour show. As far as I'm concerned, I'm still nursing. Only this is more fun!"

What she likes about TV is easy to see: the excitement and activity of the studio and the wonderful variety of people she meets in her daily work.

One of these visitors to her show was Victor Borge. "He has such a reputation for wit and sharp repartee that I was scared to death," Jane now admits. "I was afraid I'd be absolutely tongue-tied the minute we got in front of the cameras!

"So before the show I said, 'Look, Mr. Borge, I'm not an actress. I'm a nurse. And I'm for real. Please don't be too hard on me!'

"Well, he was so nice and we had such fun during that interview that I just threw my arms around him and hugged him when it was over!"

Jane's favorite mother-interviewee to date is actress Julie Harris. "I actually didn't interview her," she says. "I just listened! She told me all about her little boy's feeding problem and how she fretted over it till she realized he'd start eating regularly when he was ready."

The problem Julie Harris discussed is just the sort of thing Jane tries to get mothers to talk about ad lib. She has a few notes with her indicating questions she wants to ask the parents, but otherwise there is no prepared script.

"Sometimes I goof," laughs Jane. "I get carried away and forget some questions a skilled interviewer might ask.

"But the producers don't seem to mind. They say they hired me as a registered nurse with a nice personality and that's all they want me to be.

"I've never taken any acting lessons. I don't want to. I just want to be myself."

Aside from the colorful theater personalities she sometimes interviews, Jane often talks to doctors too. "My biggest thrill," she says, "was meeting Dr. Bela Schick, the man who discovered the test for diphtheria."

But most important of all to Jane are the babies. "They're the real stars of the show," she emphasizes. "You just can't tell

what they're going to do once the cameras start rolling.

"During the half-hour rehearsal they may be as good as gold and do everything you want them to. Then the minute you're on the air they just won't budge!

"But I don't really mind. My whole theory of child care is that babies are individuals; and I can't very well object if they pick show time to prove it."

Jane's working day is long and demanding. She gets up at 5:30 A.M. and is at the studio by 7:00. Then follows an eight-hour day of rehearsing, doing the current day's show, and getting ready for tomorrow's. After that there are letters to answer, research and study to do, and facts to check with her doctor-consultants.

After hours, as Mrs. James Palmer, Jane attends lectures and classes in pediatric nursing, reads books on child care, and dreams up ideas for the show. Then she gets her uniform ready for the next day's program.

"Uniforms are one of my biggest problems," she says. "I choose them myself because I want to be sure they're what I think a registered nurse should wear. I have to tint them, and my caps too, every single time they're washed, to be sure they're the exact shade of pale blue that looks white on television."

TV nursing is a far cry from regular nursing. For, as Jane points out, "When you go home at the end of an eight-hour hospital shift, you know the nurse who takes over will take just as good care of the patients as you did. My TV job, by contrast, is up to me and nobody else. What I tell the mothers has to be the best information available.

"The A.M.A. worked with me on all the scripts for 'It's Baby Time,' and now one of their representatives and half a dozen doctors are consultants for my present show. But I still have to do all the groundwork myself."

At that, Jane enjoys the chance to mix education with entertainment. She knows she is reaching more mothers and babies than she ever could as a hospital or public health nurse. The letters she gets from grateful parents convince her that she's helping them and their babies.

And what about the future?

"I'm going to enjoy the show as long as it lasts," says Jane Warren. "After that I'm going to be plain Mrs. Jimmy Palmer and have babies of my own." END

Helping the Sick Chi

By Marion O. Lerrigo, PH.D.

"My child's terror in the hospital, where he was alone with strangers who were hurting him, would have been less if I'd been in the same room," a mother wrote to her pediatrician. "For weeks after he came home, he screamed whenever we left him."

You'll agree that no child needs to suffer in this way. And the pediatric staff of Connecticut's Grace-New Haven Community Hospital feels the same way. It avoids, or at least plays down, anything that might cause psychic trauma in its child-patients.

This staff believes that hospitalized children get well more readily if they can be made to feel more or less at home, especially if there's someone standing by with love and concern for them. And in the great majority

FOR THEIR COOPERATION *in supplying data for this article, the author is indebted to the following staff members of Grace-New Haven Community Hospital, New Haven, Conn.: Milton J. E. Senn,* M.D., *director of the Yale University Child Study Center; Marian Weinberger,* R.N., *instructor in children's nursing; Elizabeth Childs,* R.N., *administrative supervisor of children's service; Cynthia Moller, instructor in diversional therapy; and Edith Olson, play supervisor.*

Chi Help Himself

of cases, the best "someone" is either the small patient's father or his mother.

So parents are welcome at Grace-New Haven. They stay with their child during admission, go with him to his room, are present whenever possible at the time the doctor examines him.

They can visit for hours on end—any time from 2:00 to 7:00 P.M. In some cases the mother even sleeps at the hospital, in the room with her child.

But there's more for a mother to do at Grace-New Haven than merely supply affection. The

THESE DRAWINGS, *done by 11-year-old Bobby Bell of East Hampton, Conn., while gravely ill with leukemia, show graphically some of the reactions of a youngster to his environment when he's hospitalized. Even more to the point, they suggest how dependent he is on the understanding of the nurse and the contributory efforts of volunteer workers. For permission to bring you these drawings,* RN *thanks The Women's Auxiliary of Connecticut's Grace-New Haven Community Hospital.*—THE EDITORS

nurse makes sure the mother understands the case, answers all her questions, and encourages her to help in all suitable ways with her child's care. Thus his feeling of closeness to his mother is maintained. His fears are relaxed. And he's made ready to accept the care given by others.

Naturally the R.N. can't always use the mother's help. But before saying so she makes sure her reason is valid. Then she tells her reason to the parent.

It's imperative that there be no rivalry between nurse and mother. Almost every child can sense such disharmony when it exists, and his recovery may be delayed because of it.

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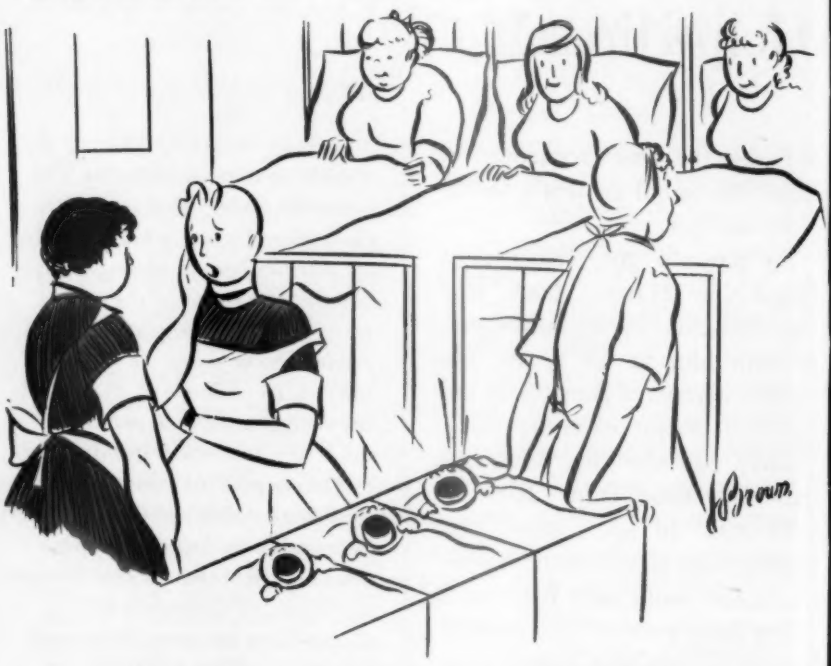


"Oh, fine—their gowns are on backwards."

But bringing parents into the picture isn't the only way to make children feel at home in the hospital. They want to make their own little "houses"; so it's better not to move them from room to room, or even from bed to bed.

The Sign Painters

Recently we saw evidence supporting this belief on the doors at Grace-New Haven. Gay signs, painted with help from volunteers, labeled each child's room as *his* place. There was "Dolly's Den," scrawled in big red letters against blue sky, white clouds, and yellow flowers. Next door a drawing of a saucy snow man boasted, "I'm Sammy from Icicle Hill."

Routines like those at home also help the child to feel comfortable. For example, the nurse asks about his bedtime habits. Does he sleep with the light on? Take a favorite toy to bed? Say his prayers? Want a drink? Prefer to be sung to, or to hear a story? The nurse asks, too, about the child's toilet habits and the words he uses for these needs.

To increase further the youngsters' feeling of security, one nurse is assigned to a group of children, for whom she does everything. Because each child has one nurse who is "his" and one doctor who is "his," and sees them regularly, he soon gives them his confidence. The vital relationship of trust that develops makes him more receptive to their healing efforts.

This system of total patient assignment is considered sounder for the well-being of the whole child than its opposite—functional assignment.

Almost Like Home

"At home" feelings are furthered by allowing a reasonable amount of liberty. So each small patient is given as much free activity as is safe. For example, children can leave their rooms, walk in the corridors, visit each other, go to the bathroom, or ask in the kitchen for snacks.

Such an atmosphere shifts the child's attention from what he *can't* do to what he *can* do. It aids in overcoming the fear of helplessness that ill children often experience.

Of course, growth is always uneven, and some sick youngsters need the comfort of slipping back into babyhood. Three-year-old Sue, for example, is sucking

her thumb while at the hospital, though she doesn't do so at home. This sort of thing is usually a temporary defense against the anxieties of illness. No child is forced to give up such defensive reactions at Grace-New Haven.

By far the best weapon against anxiety is knowledge. But children's ideas about the body and about hospital experiences are generally not well rooted in reality. As a result, youngsters suffer needless fears of the unknown.

No Secrets

The obvious solution is to do away with the mystery, and hence with the fear. The child should be prepared in advance for whatever may be new, painful, or frightening. For example, the thoughtful nurse lets her charge know that she'll be on hand during the night. If she must give a treatment, she wakes him and tells him what she's going to do. Whenever he's to be taken from his room, she tells him where he is going and where his parents will be, and that they'll be waiting for him when he returns.

Before surgery the child is told the color of the operating room, and that the doctors will wear green suits and helmets with holes for their eyes. (This might be a congenial sight to junior spacemen!)

But some things are not predictable, and a certain amount of leeway is necessary so that neither parents nor child will think they've been lied to. For instance, in preparing a child for anesthesia, the nurse says, "They'll probably give you something to smell so you'll go to sleep." If the child asks, "Will they stick me again?" she replies, "Maybe. But usually they just give you something to smell."

Or, if a child asks how long he'll be in the hospital, the nurse answers, "I don't know, but we'll get you home as fast as we can."

If a treatment is apt to be painful, she reassures the youngster beforehand. "This needle will hurt some, but only for a minute," she may say.

'You Can Help'

Often she gives the child a chance to cooperate in his treatment, perhaps suggesting, "You can help us by lying very still." This gives him the feeling that he's sharing the responsibility.

Prior knowledge is especially

helpful in such cases as spinal puncture, one of the most frightening experiences to children. Often the doctor thinks only that it's safe and can be painless; he forgets that the procedure itself may be terrifying.

Explain the Procedure

Because of the restraint applied, the child may think he's being punished. He's frightened because he can't see what's going on. Explanation beforehand helps avoid difficulty.

Some ways of phrasing information are less disturbing than others. In explaining intravenous feeding, for example, the nurse says, "There'll be a bottle hanging beside your bed and a tube going into your arm" (not "a needle in your arm"). By the same token, "You're going to have your tonsils fixed" is less frightening than "You're going to have your tonsils taken out."

Showing—if it's possible—is even better than telling. Suppose a child is to be in restraint following surgery for cleft palate. The nurse puts on the armboards before the operation so he can get used to them.

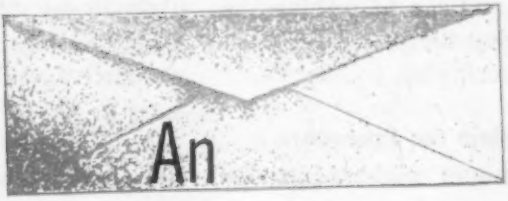
In spite of explanations and demonstrations, there'll be times when the little sufferer needs to cry, simply because he's little and suffering. Out of deep-rooted social custom, the nurse is likely to say, "Don't cry; you're a big boy now." (She probably wouldn't say that to a girl in tears.)

Actually, it's best if both boys and girls give way to an honest expression of feelings. In pain or illness there may be more therapeutic value in shedding tears than in holding them back. But if the youngster prefers not to cry, he needs support in *that* choice.

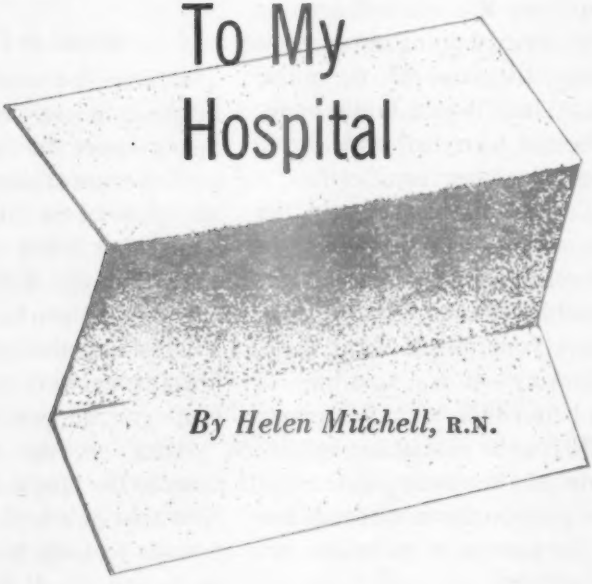
Advice to Parents

Before the child leaves the hospital, nurse and doctor can help prepare the parents to cope with the uncertainties that usually follow the first forty-eight hours after home-coming. What shall they do if he refuses his medicine or won't eat his supper? And how active should he be? Specific answers to these questions can be genuinely helpful.

After all, the small patient came to the hospital to get cured. Now that he's well, it's up to his parents to keep him so. But it's up to you, the R.N. in the case, to see that they know what they're doing. END



An Open Letter To My Hospital



By Helen Mitchell, R.N.

Gentlemen:

This letter to you who run my hospital—and those who run other hospitals—will be brutally frank. But it has a constructive aim; so I feel it's justified.

A recent article in *RN* said that today's rapid turnover of staff nurses is hitting you where it hurts most: in the budget.

So what, you ask, can hospitals do to induce R.N.s to stay put?

I'll tell you what: You can update your antiquated personnel policies. They're at least twenty years behind the times.

As any hospital nurse can testify, patient care is deteriorating every day. And it's going to get a lot worse unless you and others like you who run our hospitals wake up to the sore spots in staff duty.

What are these sore spots?

You know the first: It's *low pay*.

You know that this is the chief cause of our discontent. And you know that we deserve more money. But I don't see you doing anything about it.

True, you give us a monthly raise ($10 to $15, usually) at the end of our first year—plus similar raises each year for a while thereafter. But in five years we've reached the top. And what have we got then? Maybe $300 a month—or just about what a girl fresh from secretarial school is paid in many a business office nowadays.

I ask you: Is that the true value of our professional training and years of experience? Are we to be paid, like clerks, only for time served and not for what we know?

Merit raises—pay boosts for work well done— are almost unheard of in the hospital field. I could count on the fingers of one hand the nurses I know who ever got one.

And what about overtime? How do you stack up with industry on that?

You don't! Only *one* R.N. of my acquaintance gets time and a half—and then only when she's doing OB work.

It's not that nurses have suddenly become money-mad. The

THE AUTHOR, *in order to express herself without restriction, writes here under a pseudonym.*

fact is: Many of us have hesitated to request increases for fear that higher pay for us will mean higher bills for patients, many of whom can't afford any more.

No, we're not greedy. Nor do we seek to fatten up some union's strike fund.

But we *do* have the same needs as other Americans, and we have to pay the same prices. And you know what today's prices are.

About Fringe Benefits

Remember, too, that our pay —such as it is—is just about all we get for our work. Sure, we have a two-week annual vacation with pay—sometimes three weeks after five years' service. But that's about the extent of it. Hospitals' help-wanted ads show all too eloquently how few and far between fringe benefits for R.N.s are.

There's no excuse for this, either. Fringe benefits cost you comparatively little, yet they have high value for the recipient and pay off handsomely in terms of a contented, loyal staff. Here are several such benefits that call for your early consideration:

¶ PENSION PLANS. Social Security, with $108.50 a month as the maximum benefit, isn't much to look forward to at retirement. That's why many businesses have supplementary private pension plans for their staffs. But we don't. And how many other hospitals do? Not one in five.

¶ LAUNDRY. Is there any earthly reason why *every* hospital can't launder its nurses' uniforms free of charge? The saving to us is relatively much greater than the cost to you.

¶ MEALS. Some hospitals offer free meals during on-duty hours. But ours doesn't. I believe it should.

¶ HEALTH INSURANCE. Here again, industry has left hospital management far behind. Some companies pay half the premium for employe coverage. Many—including plenty of small concerns—pay the entire premium. Giving this protection to your nurses and others is one of surest —and cheapest—ways to build a stable staff.

¶ LIFE INSURANCE. In these days of group coverage, why are so many hospital nurses also without life insurance? It can't be because hospital managements don't know about group coverage. Is it because they don't care?

Still other objectives must be

set up that will make for better personnel relations and less staff turnover. For example:

A forty-hour week (still a rarity in nursing).

Bonuses for week-end and holiday duty.

Cumulative sick leave.

Paid time for attending professional meetings.

Discounts on pharmacy purchases and hospital bills.

Fewer work hours on week-ends.

Easing of shift rotation.

Higher pay for evening, night, and week-end work.

Days off to compensate for unused sick leave.

Longer vacations.

Baby-sitting service.

Benefits like these are common today in business and industry. In hospitals, they're conspicuous by their rarity.

Can you wonder, in view of all these things, why hospital R.N.s are less wedded to their jobs than they used to be!

Some institutions, I realize, are trying to update their policies. But the vast majority still have to discover how really far behind the times they are—especially in the matter of pay and pension plans.

One word more: Don't think that the nurse's material needs are causing her to slight her professional ideals. All of us earnestly want better supervision, more in-service programs, and refresher courses that will bring back our inactive colleagues. With us, the patient comes first, and always will.

But we still have certain needs as human beings that must be met if we're to continue in nursing.

What are you going to do about them? END

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If You Need Bo...

Suppose you've had a run of bad luck. Suppose you're in the red $300 on account of car repairs, new plumbing, and allergy shots. To get out of this financial hole and safeguard your credit rating you need money—fast.

What to do? Where to go for the green stuff?

First, you go to your creditors and tell them about the spot you're in. If you're employed and your past credit is good, they may let you pay up a little at a time.

But if your creditors are breathing down your neck, you take another way out: You borrow.

When you do so, you have lots of company. At last report, U. S.

How Long.....

Number of Dependents Including Wife .....

To .....

Year.....

Key Facts Worth Knowing . . .

Borrow Money

By A. R. MacDonald

consumers had piled up nearly $8,000,000,000 in personal debts to credit unions, loan companies, banks, and other agencies.

Your reason for borrowing isn't unique, either. One loan company reports that about 22 per cent of its customers borrow to pay overdue bills.

In consolidating your debts this way, you're only robbing Peter to pay Paul. But if you're gainfully employed, it's probably worth it. For, barring further emergencies, you then have only a single creditor, the loan agency.

Paying overdue bills is, of course, only one reason for borrowing. For example, one nurse who had always thought there was "something not quite nice" about borrowing money says, "When I needed cash for a long-distance plane ticket to visit my sick mother, I didn't think twice about getting a loan."

Actually, there's no reason to be ashamed of borrowing. After all, you're not asking for charity. You're merely renting some cash for a while.

But finding the cash-rental plan best suited to your special need may take a bit of doing. For those who loan money offer a variety of prices and services. And they will insist on your signing a legally binding contract.

In shopping for a loan, it's wise to check sources within your profession. A recent *RN* survey indicates that you'll be lucky to find one near you; but better

look anyway. Here's what the survey reveals:

¶ Only eight alumnae associations, two state nurses associations, and one staff nurses association out of 235 groups that replied have funds for emergency loans.

¶ There is at least one credit union exclusively for nurses: the Nurses Credit Union of Minneapolis.

Some Hospitals Lend

¶ Three hospitals say they make loans on an individual basis. (Undoubtedly other hospitals also do this but aren't anxious to advertise it.)

¶ Twelve hospitals report credit unions for *all* their employes, including nurses.

Credit unions are, in effect, cooperative clubs. They operate under state or Federal supervision and make loans to members from their common savings fund.

Because credit unions are geared to serve closely knit groups, such as hospital employes or social clubs, members generally know each other—which, in itself, is good insurance against nonpayment of loans.

Another credit-union asset is low overhead, since the officers usually serve without pay. This saving is reflected in relatively low interest rates—generally about 1 per cent a month on the unpaid balance. A credit-union loan of $100, for example, would cost $5.50 in interest if paid off in ten monthly installments, or $12 if paid off in a lump sum at the end of the year.

Many credit unions lend as much as $400 on a borrower's signature alone. Or you may get a higher loan if security is offered by co-signers (persons who agree to make good on the loan if the borrower defaults) or via pledges of personal property (commonly called chattel mortgages).

Credit unions lend money for emergencies; for education; for consolidation of existing debts; or for the cash purchase of an automobile, furniture, refrigerator, and the like.

You can also borrow from small-loan or consumer-finance companies. These agencies are in the moneylending business for profit. Their maximum loans range from $300 to $1,000, with state law governing the ceiling amount. Charges run from 1 per cent to 3.5 per cent a month, or from 12 to 42 per cent a year, on the unpaid balance.

Suppose a finance company lends you $100 at 3 per cent per month. If you pay it off in ten months, it may cost you $16.50. This is far steeper than the $5.50 cost of the $100 credit-union loan. Still it's within legal limits, and it reflects the overhead expense and profit margin of the small-loan company.

Like credit unions, loan companies make many loans solely on the borrower's signature. Other loans are secured by cosigners, chattel mortgages, or assignment of wages. If you fail to repay a loan secured by wages, the finance company can collect from your employer. (If a chattel mortgage is involved, the lender can take possession of your pledged property through legal action.)

Even though most loan agencies are on the right side of the law, it's a good idea to check credentials. Does the agency have a license prominently displayed? Will it give you—*in writing*—the date of the loan, its maturity date, the security required, the name and address of borrower and agency, and the rate charged? If not, you'd better head for the nearest exit.

Plenty of people, including nurses, have fallen prey to shady operators. And some have ended up paying many times the value of their loan in interest. One R.N., rescued from a loan shark by the Nurses Credit Union of Minneapolis, was paying $14 per month on a $300 loan. In a year, this would have totaled $168, or nothing less than 56 per cent of the principal!

Banks Are Best

Ordinarily you can't find a better source of cash than the personal loan department of a commercial bank. But remember, interest rates on small bank loans are relatively higher than on large ones. The reason: Overhead costs the lender the same in either case. But in any event, the total cost is substantially less than the charges of most other lenders.

You may find, too, that loan charges on personal bank loans are expressed as "discount rates." In other words, the cost of the loan is "discounted" or deducted in advance. This means you don't get the full face value of your loan. Nor do you have the use of all the money for the full term of the loan, since you're repaying part of it each month. Net

result: the true interest rate is nearly double the discount rate.

How does this work out? If you borrow $100 at a discount rate of 3.83 per cent, you receive only $96.17 ($100 minus $3.83). Since you reduce this debt in twelve equal installments, the average amount you get to use during the year is roughly half of $96.17. So your *true* interest rate is more than 7 per cent, or about double the discount rate. But remember that this 7 per cent is an *annual* rate, and is equivalent to about 0.58 per cent a month.

Which Type of Loan?

A nondiscount loan, if you can get it, may well be better than a discount loan. There's also the "add-on" loan to consider. In an "add-on" loan, interest is *added* to the sum borrowed and then repaid along with the principal. Which type loan will be most economical for *you* can be determined only by figuring out the *true* interest you'll pay. Don't fail to do this before you borrow.

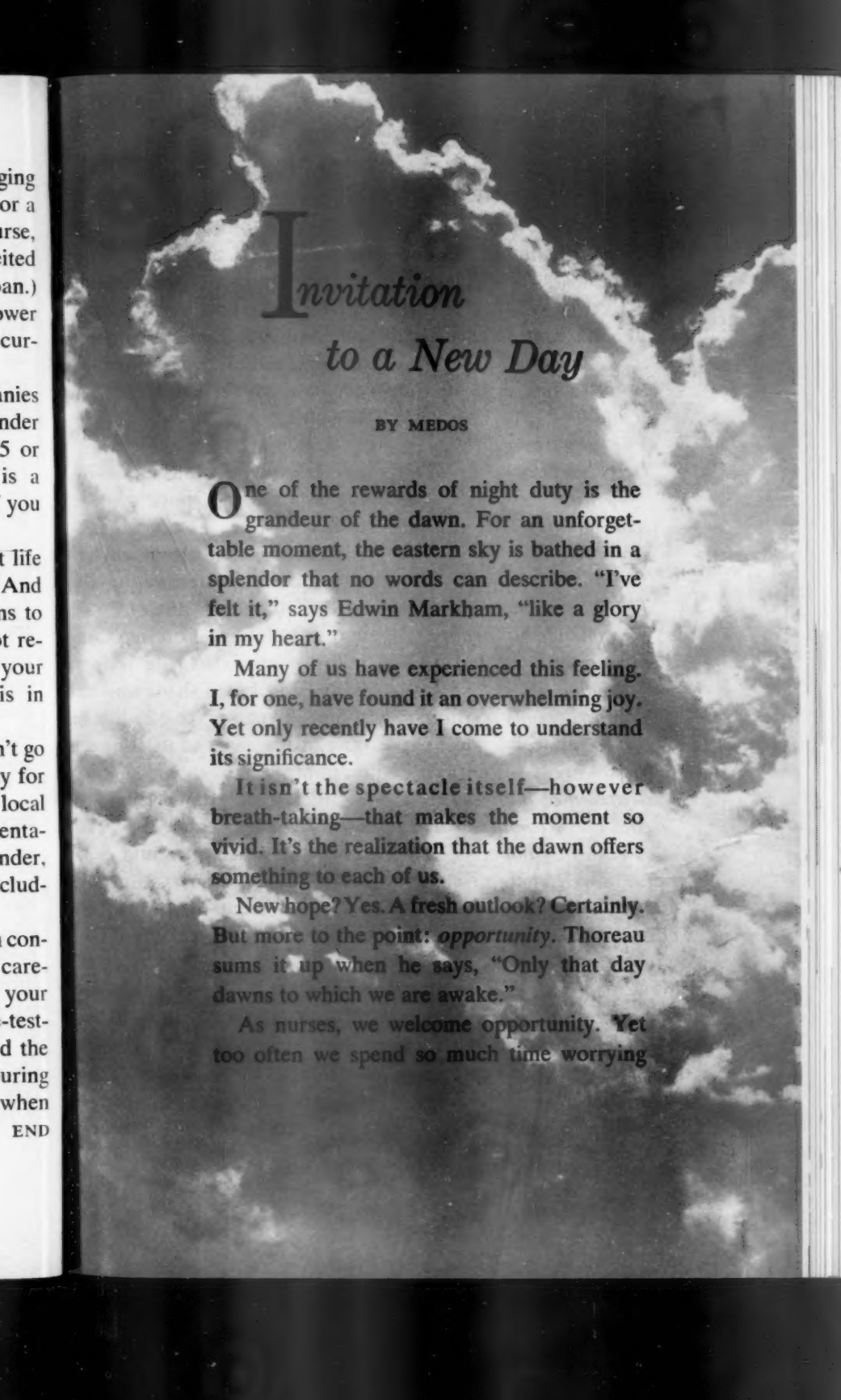
Banks often lend money for longer periods than other agencies, but their credit standards are apt to be stricter. Co-signers are required for some loans. Others are secured by pledging securities, an automobile, or a savings passbook. (Of course, any of these would be forfeited should you default on your loan.) As a rule, borrowers get a lower interest rate when a loan is secured by collateral.

Most life insurance companies lend up to the cash surrender value of a policy at about 5 or 6 per cent interest. This is a source worth investigating if you have a policy.

Usually banks will accept life insurance as collateral, too. And this is one of the best means to such a loan since it does not reduce the face amount of your insurance while the loan is in effect.

Bear in mind that you can't go far wrong if you shop wisely for your loan, talk to your local bank's personal loan representative, deal with a licensed lender, and know exactly what's included in the charges.

In other words, don't sign contracts blindly. Read them carefully so that you know your rights as a borrower. A time-tested rule in nursing is to read the label three times before pouring the medicine. Don't do less when you take a dose of debt! END



Invitation to a New Day

BY MEDOS

One of the rewards of night duty is the grandeur of the dawn. For an unforgettable moment, the eastern sky is bathed in a splendor that no words can describe. "I've felt it," says Edwin Markham, "like a glory in my heart."

Many of us have experienced this feeling. I, for one, have found it an overwhelming joy. Yet only recently have I come to understand its significance.

It isn't the spectacle itself—however breath-taking—that makes the moment so vivid. It's the realization that the dawn offers something to each of us.

New hope? Yes. A fresh outlook? Certainly. But more to the point: *opportunity*. Thoreau sums it up when he says, "Only that day dawns to which we are awake."

As nurses, we welcome opportunity. Yet too often we spend so much time worrying

about yesterday's difficulties and tomorrow's uncertainties that, before we know it, today has slipped through our fingers and opportunity is lost.

The extent of this loss is brought home to us in an age-old poem:

Look to this day, for it is life—
The very life of life!
In its brief course lie all the verities
And realities of your existence:
The bliss of growth,
The glory of action,
The splendor of beauty.
For yesterday is but a dream,
Tomorrow only a vision.
But today well lived
Makes every yesterday a dream of happiness
And every tomorrow a vision of hope.
Look well, therefore, to this day!

This day . . . this priceless Now! Are we to waste it, for example, harboring a jealousy sprung from yesterday's punctured pride? Are we to lose what it offers, for example, bemoaning the fact that we can't have tomorrow off as planned?

Thus do we squander the opportunities of Now.

Samuel Johnson, never one to mince words, bids us to "Learn that the present hour alone is man's." Yet how many a "present hour" is ruined—either by indulging in self-pity over past events or by fretting over things to come!

Somebody once said he had lived through a thousand terrifying experiences—none of which ever occurred!

True, our tomorrows will have —just as our yesterdays have already had—a measure of trouble and tribulation. For, as Longfellow reminds us, life is inevitably "checkered shade and sunshine." Even so, we can live life only as it's given to us: one moment at a time.

"Finish each day and be done with it," says Emerson. "You have done what you could. Some blunders and some absurdities no doubt crept in; forget them as soon as you can. Tomorrow is a new day; begin it well and serenely with a spirit too high to be cumbered with your old nonsense . . . [The present] is too dear, with its hopes and its invitations, to waste a moment on the yesterdays." EN

Drugs for the Toxemia of Pregnancy

By Morton J. Rodman, PH. D.

Childbirth was never safer. Yet some women still die during pregnancy. And an even greater number of infants are lost at birth.

Acute toxemia is the killer in nearly one out of every three maternal deaths. It's the most common cause of stillbirths, too, and of deaths among the newborn.

Yet most of these mothers and infants don't have to die. Proper prenatal exams can detect toxemic symptoms before the condition has made any real headway. And new drugs can now keep toxemia from progressing to eclampsia—its final, and often fatal, stage.

These drugs don't strike at the actual cause of toxemia. That's still a mystery. But they can correct the chief symptoms: fluid retention and high blood pressure. They can control eclamptic convulsions, too. So the baby, instead of being delivered prematurely, can stay in the uterus longer—which gives him a fighting chance to survive.

A slight puffiness around the eyes, as well as in the ankles and hands, is an early sign of preeclampsia. This does not necessarily mean the onset of toxemia. But the alert doctor takes no chances—not when he can often nip the toxic state by simply putting the patient on a low-salt diet at the first evidence of fluid retention and by getting her off her feet for a while.

This works for most women. But some stay bloated and keep

THE AUTHOR is *Professor of Pharmacology at the College of Pharmacy, Rutgers University, Newark, N. J.*

putting on weight—sometimes several pounds in a few days. Their output of urine falls, and what water they do pass may be high in protein content. Such albuminuria, together with a rise in blood pressure, blurring of vision, and severe headaches, may spell real trouble.

These symptoms call for prompt treatment. Diuretics—to drain salty fluids from the tissues

Centrally Acting Antihypertensive Agents

Generic or Chemical Name	*Trade Name or Synonym*
Hydralazine HCl, N.N.D.	Apresoline
Veratrum viride and Veratrum album alkaloids:	
Alkavervir, N.N.D.	Veriloid, Vergitryl
Cryptenamine acetates, N.N.D.	Unitensin acetates
Cryptenamine tannates, N.N.D.	Unitensin tannates
Protoveratrines A & B, N.N.D.	Veralba
Protoveratrines A & B Maleate, N.N.D.	Provell maleate
Rauwolfia serpentina alkaloids:	
Rauwolfia serpentina (whole root), N.N.D.	Raudixin, Rauserpa, Rauval
Alseroxylon, N.N.D.	Rauwiloid, Rautensin
Rescinnamine	Moderil
Reserpine, N.N.D.	Serpasil, Sandril, Serfin, Serpiloid, Serpate, Rau-sed, Raurine, Reserpoid, Rauloydin, Roxinoid, *et al.*
Rauwolfia canescens alkaloid:	
Deserpidine	Harmonyl

—can be very effective here. Until recently, only ammonium chloride and the organic mercurial diuretics were available. Either may do the job. But both have disadvantages.

Ammonium chloride is adequate only when not too much fluid has piled up. It rarely works well when there's a lot of water trapped in the tissues. The mercurials are much more effective. But some doctors say they aren't nearly so satisfactory in toxemia as they are against the edema of congestive heart failure. Also, unless used with great care and judgement, they may damage already delicate kidney tubules.

New Diuretics

Several new diuretic drugs have recently been introduced for toxemia treatment. Among them are acetazolamide (Diamox), aminoisometradine (Rolicton), and chlorothiazide (Diuril). Unlike most mercurials, these agents are effective and well tolerated when given by mouth; people rarely become permanently resistant to their diuretic action; and their side effects, though present, are rarely serious.

Aminoisometradine *does* make some patients nauseated. Acetazolamide causes drowsiness, even disorientation occasionally; it also gives some people a peculiar "pins-and-needles" sensation around the lips and in the limbs (paresthesia). Chlorothiazide, a chemical relative, may do the same. And, like other potent diuretics, all of these sometimes dehydrate patients or throw their fluid-electrolyte balance out of kilter.

They Can Work Too Well

This may happen if the drugs do their work too well. That's because they all act by keeping the kidney tubules from reabsorbing some of the sodium and other ions filtered through the glomeruli. The electrolytes are then excreted along with the water they're dissolved in. That's what makes the edema clear up so dramatically.

But sometimes too much of a particular chemical is excreted. The result: acidosis, alkalosis, or other body-chemical imbalance.

Acetazolamide, for example, removes bicarbonate from the blood and body fluids along with excess sodium. The loss of this base from the body produces a mild acidosis. Chlorothiazide, it's

claimed, doesn't do this; it doesn't excrete excessive amounts of bicarbonate; instead, it rids the body of sodium and chloride in equal proportions.

This "saluretic" or salt-removing action of chlorothiazide gives it an advantage in toxemia treatment because keeping body salt low seems to reduce blood pressure. Doctors have given chlorothiazide to patients who wouldn't stick to unpalatable low-salt diets and have found that blood pressure fell even when these patients salted their food. The drug also seems to increase the effectiveness of all the common blood-pressure-reducing agents.

Why the blood pressure soars in toxemia is uncertain. Some doctors think it starts when pressure by the uterine contents cuts the placenta's blood supply.

New Oral Diuretics

Generic or Chemical Name	*Trade Name or Synonym*
Acetazolamide, N.N.D.	Diamox
Chlorothiazide	Diuril
Aminometradine, N.N.D.	Mictine
Aminoisometradine, N.N.D.	Rolicton
Ethoxzolamide	Cardrase

Sedative, Tranquilizer, and Anticonvulsant Agents

Generic or Chemical Name	*Trade Name or Synonym*
Magnesium sulfate injection, N.F.	——
Chlorpromazine HCl, U.S.P.	Thorazine
Promazine HCl, N.N.D.	Sparine HCl
Promethazine HCl, N.F.	Phenergan HCl
Paraldehyde, U.S.P.	——
Chloral hydrate, U.S.P.	——
Morphine sulfate, U.S.P.	——
Thiopental sodium, U.S.P.	Pentothal sodium
Amobarbital sodium, U.S.P.	Amytal sodium

This, they say, triggers the release of vasoconstrictor hormones, which circulate all over the body, tightening vessels everywhere. Others believe that toxic proteins produced by damaged uterine tissues set off generalized vasoconstriction.

No matter what the cause, the result is undesirable—a reduction in blood flow to vital organs and a rise in pressure as the fluid has to force its way through narrowed channels. If pressure doesn't come down quickly, the eyes, brain, liver, and kidneys may suffer irreparable damage.

Such hypertensive crises can even lead to death from cardiovascular collapse or cerebral hemorrhage. Lowering the blood pressure is therefore essential.

Drugs that act centrally appear best for achieving this end. They cut the flow of constrictor impulses from the centers that control vascular tone. This seems to work better than does intercepting the messages at more outlying sites, e.g., at the sympathetic ganglia, or in the blood vessels themselves.

Reserpine and other Rauwolfia alkaloids, for example, are believed to act by suppressing the outflow of sympathetic constrictor impulses from the hypothalamus. These plant products are quite effective in mild pre-eclampsia. They usually keep pressure down even when given in doses that cause only such mild side effects as stuffy nose and drowsiness. This sedative action may even be useful in toxemia.

But reserpine alone doesn't do so well in actual eclampsia, even when it's injected. Its action is too slow and uncertain. So it's usually combined with more potent, quick-acting drugs such as the alkaloids from another plant, Veratrum, or the synthetic chemical, hydralazine hydrochloride (Apresoline).

How They Work

These drugs often produce a dramatic drop in blood pressure. They're usually given by intravenous drip in severe pre-eclampsia. This sends pressure down to normal in as little as five to ten minutes. Once it has stabilized at a safe level, the patient may be put on intramuscular medication. Later she may even be shifted to oral therapy and allowed to leave the hospital.

But ambulatory patients may suffer some [MORE ON 100]

When Your Cirrhosis Patient Hemorrhages

Rupture of the esophageal varices demands real nursing talent and knowledge. Are you ready to meet the challenge?

By Richard H. Miller, R.N.

I've done a lot of bedside nursing and expect to do much more. Whenever I have a choice of patients and there's one with cirrhosis, that's the one I take.

Why? Because a cirrhosis patient is so critically ill that he's a real nursing challenge. I have to marshal all my professional resources when I care for him; and that's the way to become a better nurse.

This is the sort of thing that happens:

A nurse, we'll say, has given a hundred hours or so of care to a patient with cirrhosis. His skin is improved. His appetite is back. His ascites is lessened. So perhaps she sighs with satisfaction and says to herself, "Thank Heaven he's getting better now!"

If she does, she may have to swallow her words. For such a patient, without any warning at all, may suddenly begin projectile vomiting of bright red blood; in which case one of the most dreaded complications of cirrhosis—ruptured esophageal varices—will have set in.

Nearly 50 per cent of patients with this complication die within a year of their first hemorrhage. Among those who survive the first hemorrhage and have a second, the mortality is 80 per cent.

Esophageal [MORE ON 88]

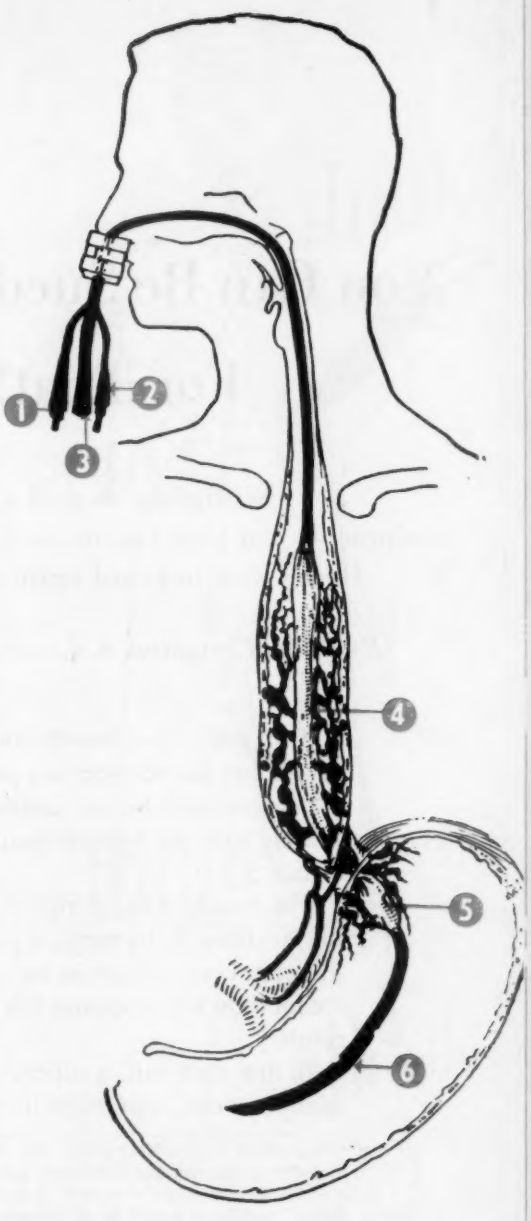
THE EDITORS *of* RN *gratefully acknowledge the cooperation of Drs. A. Hendley Blakemore and Arthur Patek Jr. in the preparation of this article. Both are national authorities on liver diseases. The author is a graduate of the Mills School of Nursing, Bellevue Hospital, New York, and has had wide experience in the care of cirrhosis patients.*

The Blakemore tamponade illustrated here has, in many cases, proved itself a life-saver by its ability to stop hemorrhaging of esophageal and gastric varices. It consists of a three-lumened tube with two balloons.

The doctor introduces the tamponade through the patient's nose, easing it into a position where one balloon (4) is in the esophagus, one (5) is in the stomach, and the distal portion of the tamponade (a gastric tube) (6) is also in the stomach.

The lumens at the upper part of the tamponade terminate in three tubes. To anchor the ends of the tubes, the doctor slips them through a slit in a one-inch foam-rubber cube and cinches the cube to the tamponade with half-inch-wide adhesive. Then, through lumen (1), he inflates the gastric balloon with 1,000 ml. of air and clamps off the tube leading to it. Through lumen (2), he inflates the esophageal balloon until an attached mercury manometer shows a pressure of 35 mm. Then he clamps that tube off. The pressure exerted by the balloons on the ruptured varices of the esophagus and stomach tends to stop their bleeding.

The doctor then lavages the blood out of the stomach, through lumen (3), using at least a liter of normal saline for the purpose. If, after that, the returns are clear, he knows the balloons have curbed the hemorrhaging. If the returns are not clear, he further inflates the gastric balloon and continues lavaging until the flow is clear.



You Can Be Sued For That!

Negligence as well as malpractice can land you in court. Here's what to guard against

By Helen Creighton, R.N., J.D.

Are those side rails down when they should be up?

Is that hot-water bottle *too* hot?

Did you triple-check that label before giving the medication?

It's easy to excuse yourself for overlooking a routine detail. But the law may call it *negligence* and may *not* excuse you. Every nurse, it warns, is liable for her own negligent acts.

That goes regardless of who employs her—and regardless of whether her services are paid for or gratuitous.

So you can't be too cautious. This is especially true in dealing with the hazards that most often lead to negligence suits.

The overlooked sponge is, of course, a common factor in suits brought by surgical patients. If a nurse fails to make a sponge count or errs in her count, and if the surgeon closes the incision with a sponge left inside, a damage suit may well result.

In one such suit, a supervising nurse, responsible for the sponge count, was held liable for negligence. A student

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THE AUTHOR *is a member of the Bar of the District of Columbia and assistant professor at Georgetown University School of Nursing. This article, the third in a series, approximates a portion of her new book, "Law Every Nurse Should Know," published by the W. B. Saunders Company, Philadelphia, 1957.*

nurse, who had simply passed sponges to the surgeon, was held *not* liable.

In another case, the surgeon was held liable. Here, a charitable hospital was not liable for the acts of the O.R. nurses since they were under the surgeon's control; but the surgeon had neither counted the sponges himself nor required a nurse to count them.

Burns also rank high among causes of damage suits. Court records show that such suits have involved hot-water bottles, heating pads, inhalators, steam pipes, radiators, scalding hot water, douches, enemas, sitz baths, sweat cabinets, diathermy, and solutions that were either too hot or of improper concentration.

In an Oklahoma municipal hospital conducted for profit, a patient recovered damages for injuries due to burns caused by a too-hot enema administered by an R.N.

Also in Oklahoma, a hospital

'NEWSHENS!'

That's what Time magazine calls the women who gather news and serve as news correspondents. Presumably the younger ones are "newschicks."

Whatever they're called, correspondents with a nose for real news are vital to any periodical that publishes news. *RN* is no exception. It has a number of valued news contributors and would be glad to hear from more.

This, then, is an invitation to share any nursing news you hear with your 170,000 fellow nurses across the country who subscribe to *RN*. You can make a little spending money at the same time.

News submitted should be of significance to nurses everywhere. *RN* can *not* use items of purely local interest, such as capping ceremonies, staff appointments, and marriages.

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was held liable when a nurse burned a postoperative patient with an unguarded lamp globe while the patient was receiving emergency care for heart failure from a physician. The emergency had taken the M.D.'s full attention, and he'd been compelled to leave other details to the nurse.

Sometimes, the patient's own negligence may be a contributing factor. When this happens, the nurse may not be liable. For example:

A patient was instructed in the use of an electric heating pad and operated it successfully for three days. Later, when he went to sleep with the current on, he was burned. In this case, neither the nurse nor the hospital was liable.

Beds a Hazard

Patients injured by falling out of bed often bring suit. So, too, do patients who slide off the edge of a high hospital bed after being allowed to get up or who fall while taking their first steps.

Accidents of this kind occur frequently among those under sedation, among postoperative patients not fully recovered from anesthesia, among persons who suffer from dizziness, and among the elderly, the blind and the semi-conscious. MORE ▶

THE 1958 RN AWARDS

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■ Your *article* will have the best chance of winning if it's (a) not more than 1,500 words long; (b) filled with examples, anecdotes, and cases in point drawn from actual experience; and (c) limited to *just one aspect* of any broad subject, whether it be clinical, human interest, economics, technical, or personal.

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■ Entries must be postmarked no later than June 30, 1958, and addressed to Awards Editor, *RN*, Oradell, N.J. Manuscripts should be typed, triple-spaced on one side of the paper only, and accompanied by a self-addressed envelope and return postage.

YOU CAN BE SUED!

In some hospitals, it's routine to place side rails on the beds of all postoperative and irrational patients and all under age 6; and, at night, on the beds of all aged 60 and over.

Obviously, delirious patients need side rails and constant observation. And when it is impossible for a qualified attendant to give constant attention, side rails should be put up as soon as an unconscious or partially conscious patient is returned to his bed after an operation.

In some states—New York, for example—the hospital is liable if a nurse fails to carry out a physician's instructions to use side rails as a precaution. (The negligent nurse, of course, can *also* be sued for this.)

Vigilance in administering medicines can't be overemphasized. A nurse can be sued for giving a wrong medicine, a wrong dosage, a wrong concentration; for administering medicine to the wrong person; for neglecting to read (or for misreading) a label; and for any similar error.

A patient in Idaho recovered damages after a nurse had negligently supplied a boric acid solution instead of a saline solution for injection into the patient's thigh.

In another case, a patient col-

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lected damages for a nurse's failure to follow the M.D.'s directions. Here, the nurse had given the patient a hypodermic injection in the hip instead of in the arm.

The danger of infection must, of course, be heeded at all times. Use of an unsterile needle, for example, can readily make a nurse liable for negligence.

Defective apparatus is another danger for the nurse to watch out for. Naturally, she can't be held responsible for *hidden* defects in equipment; but if she uses apparatus or instruments with an *obvious* defect, she's liable for injuries that may result.

Leaving the patient unattended (abandonment) is still another form of negligence for which a nurse can be sued. To illustrate:

A baby left alone by a nurse crawled too close to an unprotected radiator and was burned. The nurse was considered negligent.

In another case, a nurse left the room in the course of giving a woman a bath. The woman, left uncovered for an hour on a raw, cold morning, got pneumonia. This nurse, too, was considered negligent.

A nurse may be sued for negligence in the care of a patient's

personal belongings. Often such claims involve loss of or damage to dentures.

A simple, effective method of handling dentures is to place them in a container that's either transparent or conspicuously labeled. Wrapping them in a paper towel or piece of tissue is very risky because any unlabeled, crumpled handful of paper is likely to be picked up and thrown away.

Remember, too, that a denture can easily be damaged. For example, it may be left where something heavy—such as a dinner tray—is placed on it. Or it may accidentally be subjected to extreme heat or cold.

Obviously, the patient's clothing, money, jewelry, and other personal effects also need to be handled with care.

Any way you look at it, negligence can be costly. And it can involve *any* nurse.

If a patient is injured through negligence of a nurse-employe, both the nurse and the employer may be sued. The injured person may not collect twice for the same injury; but by bringing action against different defendants, he has a better chance of being compensated for his injury.

On the other hand, a private duty nurse serving as an inde-

"MOTHER"
by A. Lewin-Funke

Courtesy of
The Metropolitan Museum of Art

pendent contractor is *solely* responsible for her negligent acts; and the hospital in which she is working is not liable.

Either way, the consequences of legal action can be serious in terms of both time and money. A recent Washington case, for example, dragged on for eight years, no less. The persons embroiled in it had to be in court repeatedly; their time loss and mental anguish can be imagined.

Yet many a potential suit for negligence can be prevented simply by the exercise of due care. Your strongest safeguard against such suits is constant vigilance. END

[CONTINUED FROM 45] Once oxygenated blood is being delivered to the brain, the crisis has passed. There's time now to send for a defibrillator. There's time now to prepare a sterile field, to drape the patient, to have the doctor who's been doing the massage barehanded relieved by another wearing sterile gloves. The OR can be called and told to prepare for emergency closure of a thoracotomy. An IV can be started. Drugs for overcoming shock and myocardial failure can be given.

Periodic Drills

In increasing numbers, hospitals around the country are following Dr. Beck's recommendation that they hold periodic "cardiac arrest drills." In these drills, medical and nursing staffs may watch a film in which the Beck group demonstrates the technique. Or they may see an actual demonstration on an anesthetized dog. Or they may just go through the motions of practicing their assigned emergency roles.

One nurse told me of a senior resident she knows who devised a cardiac arrest drill of his own. He would come on the ward, slip into an empty room, and start shouting, "Knife! Knife!"

"He'd told us what to do if we

ever heard that call," said the nurse. "But the first few times he did it, we ran around in circles.

"Later we got so we responded to it like machines: The interne ran to do mouth-to-mouth breathing for the patient. I flew down the hall with the emergency thoracotomy tray. The aide got on the phone to call for more help.

"Actually, we never had a case of cardiac arrest while I was at that hospital. But we certainly knew what to *do* for one!"

An OR nurse told me this contrasting story:

"One night we got a call from the surgical ward to send over an anesthetist and the cardiac arrest tray. To cover the distance, even on the double, took us about five minutes.

"When we arrived, we found several doctors standing around and a sterile scalpel in the tray cabinet. But no one had done a thing about it. They were waiting for the OR people to arrive!

"Mind you, this was a surgical ward. So the neglect was that much more glaring. The patient lived; but he didn't have even so much as a cough reflex afterwards."

As more brains and more lives are saved by cardiac resuscitation done outside the OR, it's to be hoped that such lack of preparation and knowledge as this incident displays will become the rare exception.

"The public," says Dr. Beck, "has a right to expect that everything possible will be done to save the patient's life when cardiac arrest occurs. The time may come when those in medicine and nursing who fail to cope properly with this emergency will be considered guilty of gross negligence." END

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[CONTINUED FROM 72] varices rupture because the cirrhotic patient's liver function is so degenerated that hepatic circulation is badly blocked. The block forces blood back into the esophageal and upper stomach vessels; they dilate, forming varices, and often burst.

Unfortunately, there's no sure way to diagnose the presence of enlarged esophageal vessels; although in some patients they can be discovered by means of barium swallows, esophagrams, esophagoscopies, and other such tests. If your patient has taken them and shows a positive result, you'll, of course, be alert to the possibility of an esophageal hemorrhage.

But my own experience has taught me that these tests don't always reveal the condition. I've often had a patient with a negative report on all the tests who has later suffered esophageal hemorrhaging.

So my advice to nurses is this: *Be prepared for esophageal bleeding in any patient who has cirrhosis of the liver.* By so doing, you'll increase the patient's chances of survival. You'll also save yourself a lot of wear and tear if hemorrhage occurs.

How to plan ahead? Here are the preparations I make. MORE ▶

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When I have a new admission with a diagnosis of cirrhosis, I immediately read the doctor's orders. His first order is probably for a type and cross match, so I fill out requisitions and phone the lab technicians *at once*. (I do this promptly for if the patient should bleed, a transfusion would be the physician's first Stat. order, and I'd have no time then for such details as making out lab orders.)

Oxygen Needed

Next I put a tank of oxygen and a nasal catheter for administering it in the patient's unit. This is a must in the event of a rupture.

I also place a set of high shock blocks or a bed jack nearby. Then, if the patient starts to bleed, I can quickly call an aide to help raise the head of the patient's bed into high Fowler's or reverse Trendelenburg position.

When you've made these preparations, you're ready for any emergency measures that may have to be taken to *slow down* esophageal bleeding.

How Bleeding Is Stopped

To *stop* such a hemorrhage is another matter. In former days it was often impossible. But now we have the Blakemore tampon-

a special page for nurses
from Eaton Laboratories'
Medical Director
Paul F. MacLeod, M. D.

more monilia—and joining up with the trichomonads, too

While trichomonal vaginitis remains as prevalent as ever, monilial vaginitis either is increasing in incidence, or is being identified more often. Similarly, coexistence of the two infections also is reported to be mounting.

Because of these findings, it seems only rational that vaginitis therapy be effective against both organisms. Toward this end, TRICOFURON® IMPROVED was developed.

TRICOFURON IMPROVED contains a *new* specific moniliacide, MICOFUR™ (brand of nifuroxime), together with the *established* specific trichomonacide, FUROXONE® (brand of furazolidone). Its results have been gratifying: clinical cures of 85% are reported, with itching, burning and malodor usually eliminated in 24 hours.

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ade—a real life-saving device that, if applied in time, will bring the hemorrhage to a halt.

This tamponade (see drawing) is a three-lumened tube with two attached balloons. When inflated in the stomach and esophagus, these balloons press firmly on the varices and tend to stop their bleeding.

Other Items You'll Need

If your doctor is going to use the tamponade, you'll need some auxiliary items: a tube of lubricant, a one-inch cube of foam rubber with a small slit through its center, a 50-ml. syringe with an adapter, a liter of normal saline, and a blood-pressure manometer.

The accompanying illustration and caption show how we use this equipment. The procedure isn't too complicated, but it is long and tedious for both nurse and doctor.

It's worse than that, of course, for the patient. He's beset by fear that he may hemorrhage again. And perhaps he will. But you try to put his mind at rest. Proper sedation allays this anxiety.

Emphasize to the patient that

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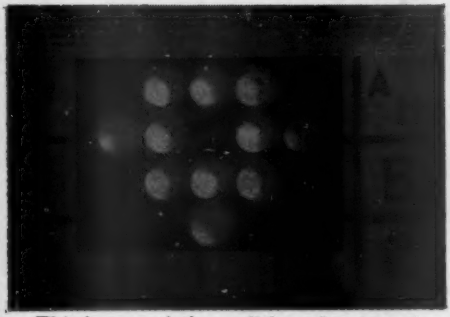

This is an artist's rendition of an actual color photograph of an irradiation rack, illuminated solely by visible blue light from Cerenkov radiation.

One experiment calls for the exposure of frozen canned foods to gamma irradiation. This photo, taken at the Argonne National Laboratory, shows cans being placed in an insulating cylinder. The cylinder will be sealed within one of the aluminum urns (at right), then lowered into the water of the radiation canal. There it is exposed to rays yielding from one to two million roentgens an hour.

High energy irradiation, alone or combined with thermal processing or freezing, shows interesting possibilities as a means for preserving packaged foods. To explore fully this new technique, American Can Company scientists are participating in an extensive irradiation research program.

Part of this work is carried on through cooperative projects at government and university laboratories, part through independent studies at Canco's multi-million-dollar Research Center in Barrington, Ill. As a result of this program, food for the nation's dinner tables some day may be sterilized by nuclear energy.

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he is to swallow nothing, not even saliva. He should be supplied with plenty of tissues, and a suction machine kept nearby.

We leave the balloons inflated for forty-eight to ninety-six hours. Then they stay in place deflated for as long as three weeks. There are good reasons for this:

(1) The patient needs tube feedings, and for this we can employ the lumen that we use to lavage his stomach.

(2) The friction caused by pulling the tamponade out too soon might induce another hemorrhage.

Tamponade Isn't Enough

Of course, the tamponade, indispensable as it has proved itself, is at best a temporary measure. The patient's only real hope of escaping future hemorrhages lies in a shunt operation. If he has this and follows the prescribed health regimen afterwards, chances are he can live free of hemorrhage.

The shunt operation is usually done some time after the patient's first bout with esophageal bleeding. But he must, of course, be a good surgical risk first. So there's a waiting period in which he's allowed to recover from his experience.

Preparation for Surgery

He gets blood transfusions; massive vitamin therapy; antibiotics; a high-protein, high-carbohydrate diet; and diuretics—much the same treatment that patients with cirrhosis generally get, except that there's more of it. Included is an exhausting series of saline enemas—often as many as ten in a row.

The enemas are an essential follow-up to the massive upper

Susceptibility factors play an important part in the occurrence and spread of athlete's foot. With the advent of warm weather, individuals who have had the disease are prone to exhibit recurrences or reinfection. Frequently, this can be prevented by the continuous prophylactic use of Desenex preparations.

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GI hemorrhage. The old blood must be removed from the intestines so that it won't produce ammonias, which the failing liver would be hard put to destroy. (Ammonia poisoning could cause a hepatic shut-down.)

When all has gone well and we can finally send the patient to the operating room for his shunt operation, we thank our stars. Better that he have surgery, we feel, than another hemorrhage with its debilitating effects.

The Operation

The operation itself may be either an anastomosis between the splenic and left renal veins (a splenalrenal shunt) or an anastomosis between the inferior vena cava and the portal vein (a portacaval shunt). Either gives the desired effect:

The closed-down hepatic circulation is bypassed. The tiny capillaries that have tried to cope with the giant job of carrying the hepatic circulation are no longer overburdened.

After the Operation

Whichever anastomosis is performed, postoperative nursing care is much the same. And it is not nearly so complicated as it was after the massive esophageal hemorrhage.

HEMORRHAGES

In such a case, I do the usual things, such as checking blood pressure, pulse, and respiration every fifteen minutes until they are stabilized, and coughing the patient every two hours to prevent atelectasis.

I also check the patient's temperature every hour for several hours. The reason:

A postoperative shunt patient normally spikes a temp. of 101 to 104. That's because a shunt is done deep in the abdominal cav-

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ity and a few of the tiny bleeders may not have been tied.

The blood in the peritoneal cavity acts as a foreign protein: It brings on a temperature elevation. So 102 degrees is no cause for alarm. But if it goes any higher, the doctor is notified.

The big postoperative job is to lower this elevation. The patient is receiving 10 per cent glucose in water, but he may need more than that to bring his fever down. So we put him in an oxygen tent and keep it at 68-72 degrees. This is a great help. We also give him alcohol sponges.

Postoperative Hazards

Warning: Never give an alcohol sponge while oxygen is being discharged. This is a real explosion hazard!

Another thing: Don't leave the patient on an alcohol-soaked sheet. Change it. If you don't, a decubitus ulcer may form before you realize what is happening.

Someone should be with the postoperative shunt patient constantly for at least forty-eight hours. He'll be *very* restless. He'll get little or no narcotic medication because his liver can't handle it. So he'll have considerable pain.

It's a Long Road Back

The shunt patient, unlike many others, is not taken out of bed for three or four days. His recovery is slow. He doesn't get a full, solid diet for at least twelve or more days. We start him off with an ounce of water each hour and increase his intake gradually.

Since most shunt patients convalesce so slowly, it's a great day when one of them you've cared for is finally ready to be discharged. You and he have come a long way together. END

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[CONTINUED FROM 71] annoying side effects. Veratrum products often cause nausea and vomiting. Hydralazine gives patients headaches and may make them dizzy and faint. These side effects can usually be corrected by reducing the dose. Sometimes they tend to disappear as the patient keeps taking the drug.

More serious is the danger of cardiovascular collapse, which may occur if these drugs are given too rapidly by vein. Protoveratrine, for example, has to be injected slowly and cautiously. The drip should be stopped peri-

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odically and the blood pressure checked continuously. Pressor drugs and atropine should be kept handy to counteract any cardiac slowing or sudden fall in pressure to shock levels.

Despite such drawbacks, these antihypertensive drugs have properties especially useful in toxemia. Veratrum reduces resistance to the flow of blood through cerebral blood vessels. Hydralazine has a similar effect on renal circulation. Increasing the flow of blood through brain and kidneys is important in acute toxemia. The better blood flow through these organs helps prevent anuria and convulsions, the two most dreaded complications of eclampsia.

Sometimes, in spite of these new drugs, this dangerous phase of toxemia develops. The victims are usually women who have neglected to seek proper prenatal care and who get around to seeing a doctor only when it's too late to prevent eclampsia. Managing such a patient is a difficult and complicated job. And here nurses have an especially heavy responsibility.

The nurse has to keep a record

of blood pressure, pulse, respiration, and body temperature. She must check urinary output hourly and see that the indwelling catheter stays in place. If the patient is in coma, she may also have to supervise suctioning of the tracheobronchial tree and administration of oxygen.

In oliguria the nurse may have to set up intravenous infusions of glucose solutions to keep the kidneys functioning. But she has to keep a close watch, for giving too much fluid may lead to pulmonary edema and cardiac failure. Signs of circulatory embarrassment or anuria require a switch to more concentrated (50 per cent) glucose solutions. These complications sometimes call for digitalization and venesection.

To Stop Convulsions

Keeping the patient quiet helps prevent convulsions. For stopping seizures, some doctors still prefer an old drug, magnesium sulfate. Concentrated Epsom salt injected intramuscularly, has a sedative-anticonvulsant action; it can usually be given about every four hours with safety. But the nurse should first

check to see that the patient has been voiding; for if the kidneys have failed to eliminate the first dose, giving the drug again could be dangerous. It shouldn't be repeated if the patient's knee jerk reflex is still knocked out.

Dangerous to Baby, Too

Magnesium sulfate is said to be a safer sedative than barbiturates or morphine in toxemia. It's less likely to cause oversedation and coma. Yet with these and *all* the older depressants, including paraldehyde and chloral hydrate, we run the risk of cutting the mother's oxygen intake. This may make the baby anoxic too.

So some doctors are trying the new phenothiazine-type tranquilizers. Chlorpromazine hydrochloride (Thorazine) and promethazine hydrochloride (Phenergan), for example, are claimed to dampen eclamptic convulsions without depressing respiration. Rapid IV drip often brings violently restless patients under control in five minutes. Blood pressure and respiratory rates fall too. But mothers and babies stay adequately ventilated.

All these medical measures may control the worst symptoms of toxemia. But delivering the baby is the only real "cure" for the condition. The trouble is that this can be dangerous during acute eclampsia.

So the time to "take" the baby is when the mother is in the best possible physical condition. That's when these drugs have stopped convulsive spasms and brought blood pressure down. Then, with the woman quieted but not comatose, the doctor can induce labor.

If the cervix is dilated, he can rupture the membranes and give oxytocin (Pitocin). Some doctors also add the new hormone relaxin (Releasin, Cervilaxin) to soften unripe cervical tissues. If all this doesn't work, a Caesarean section performed with the aid of a local anesthesia may be the solution.

We still have no drugs that actually get at the biochemical causes of toxemia. But, thanks to the new drugs we *do* have, "toxemic" mothers have a much better chance today than ever before to survive and to bear a baby that will live. END

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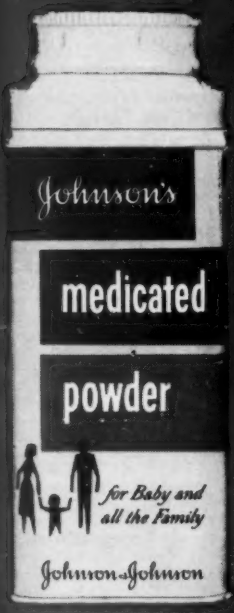

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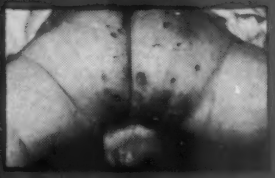

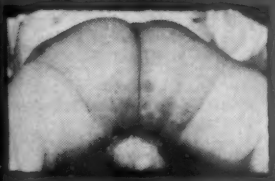

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NOTICE TO NURSES

The Surgical Products Division, American Cyanamid Company, takes pleasure in announcing a new development of outstanding importance to your hospital...and to your patients.

In the past we have worked with surgeons and hospital personnel to introduce such important product advances as the new all-purpose D & G Elliptron* Surgical Needle, the revolutionary D & G Surgilar* and D & G Surgilope SP* plastic suture packages that give you safer, stronger, more flexible sutures, and a complete line of Vim hypodermic syringes and needles.

Now, in a sweeping move to provide hospitals with faster, more efficient service and reduce hospital costs substantially, Surgical Products Division introduces a plan by which hospitals may purchase all products directly from the manufacturer!

Key personnel responsible for purchasing in your hospital are now being given full details on the DIRECT-PURCHASE PLAN. This exclusive innovation will save the average hospital thousands of dollars a year on quantity purchases...and at the same time give them the added benefit of more efficient service and new rapid delivery provided by our large staff of highly trained representatives and our unparalleled network of branch offices and regional supply centers.

The DIRECT-PURCHASE PLAN is bound to become an important topic of discussion among your hospital associates. We think you'll agree that it marks one more important step in our comprehensive program to bring your hospital the finest products at the lowest possible cost.

NEW MONEY-SAVING DIRECT PURCHASE PLAN FOR HOSPITALS

CYANAMID

AMERICAN CYANAMID COMPANY
SURGICAL PRODUCTS DIVISION
NEW YORK, N. Y.

SALES OFFICE: DANBURY, CONN.

PRODUCERS OF DAVIS & GECK BRAND SUTURES AND VIM® BRAND HYPODERMIC SYRINGES AND NEEDLES.
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sirable. Liberal personnel policies. Democratic faculty organization. Opportunity to pursue additional University work. Box CH-2 c/o R.N. Magazine, Oradell, N. J.

MEDICAL-SURGICAL SUPERVISOR: Administrative. 500 bed voluntary hosp. Degree and satisfactory experience required. Salary dependent on education and experience. Liberal personnel policies. Direct transportation to New York City in 35 mins. Write to: Director of Nursing, Newark Beth Israel Hospital, Newark 12, N. J.

NIGHT CHARGE NURSE: 11 pm-7 am, 18 bed hosp. Near summer and winter resort area. Salary $385 per mo. Southern Inyo Hospital, Lone Pine, Calif.

NURSE: Young, wanting laboratory X-ray training. Room, board, premises, free. Minimum cash with bonus $4200 plus percentage. Older retiree, nights, easy, less cash. Small clinic-hospital. Dr. Keyes, Dearborn, Mich.

NURSE ANESTHETIST: Position available immediately in dept. with 5 Nurse Anesthetists, 2 M.D. Anesthesiologists, 1 Resident. Apply Director Dept. of Anesthesiology, Abington Memorial Hospital, Abington, Pa.

NURSE ANESTHETIST: 350 bed general hospital. Want to enlarge present staff of one M.D. plus 6 anesthetists. Salary up to $425 mo. 1 mo vacation per yr plus retirement and sickness benefits. New air-conditioned operating rooms. Apply Chief, Department of Anesthesia, York Hospital, York, Pa.

NURSES: Operating Room Nurses, 7 to 3 and 3 to 11 shifts, 5 day wk, salary $350 plus call-time. 150 beds. Director of Nurses, good salary. Apply Administrator, St. Joseph's Hospital, Stockton, Calif.

NURSES: Registered, for modern psychiatric hospital in Greens Farms, Connecticut, 1 hr from New York. Hall-Brooke nurses have 8 hr duty, optional 5 or 6 day wk, nicely furnished private rooms, excellent salary, 7 pd holidays annually, or equivalent, sick lv, vacation, minimum 2 wks, maximum 4 wks dependent on length of service, profit-sharing plan, psychiatric experience not necessary. Registered or eligible in State of Connecticut. Apply Mary R. Walsh, R.N., Directress of Nursing, Hall-Brooke, Box 31, Greens Farms, Conn. Tel. Westport—Capital 7-5105.

NURSES: General duty $330 up plus $20 p.m. shifts, surgery $430 plus $10 call-out, 40 hr wk, Social Security, pd vacation, 10 days sick lv, hospital group insurance, 5 yr salary and benefit increment. Apply Director of Nurses, Corning Memorial Hospital, Corning, Calif.

NURSES: Enjoy Florida Living at its best in beautiful Miami. We invite you to join our staff in this progressive 1000 bed medical center affiliated with the University of Miami. Liberal personnel policies, 40 hr wk, free uniform laundry, evening and night differential. Starting: R.N. $270; L.P.N. $222. Write to Director of Nurses, Jackson Memorial Hospital, Miami, Fla.

NURSES: Staff Nurses. All services. Minimum salary $290, additional consideration for past experience. Head Nurses, minimum salary $330. Annual salary increases, liberal vacation, sick leave, good health insurance plan. Positions open in 228 bed general hosp. with 120 Geriatrics Service. Close Medical School and Nursing School affiliations. Located in Rocky Mountain city of 200,000 in year-round recreation area including top ski resorts nearby. Contact Director of Nursing Service, Salt Lake County General Hospital, Salt Lake City, Utah.

NURSES: General duty, 236 bed hosp 30 mi from NYC. Apartment-style resid Good salaries, free benefits and pension Modern hospital. Write Director of N ing, Morristown Memorial Hospital, Mo town, N.J.

NURSES-R.N.: Beginning salary $300, 3 gen. hosp, small industrial town (10,000 40 hr wk, 5 pd holidays, $10-20 differenti wk vacation, progressive personnel pol Write Dir. Nurses, Doctors Memorial Hos Perry, Fla.

NURSES, R.N.-GENERAL STAFF: All s available in modern suburban hospital, 2 from NYC, $285 per mo plus $25 bonu 3-11 and 11-7 shifts. Excellent personnel cies. Apply Director of Nursing, Overlook pital, Summit, N. J.

NURSES (R.N.'S): For children's camps, salary, July-Aug. Free placement. 250 m camps. Ass'n Private Camps, 55 West St., New York 36, N. Y.

OBSTETRIC SUPERVISOR: 92 bed with very active bed obstetric unit, du expansion. Modern building and faci Pleasant community. 40 hr wk, Social Sec No school. Accredited post-graduate pre tion required and previous experience able. Salary open. Apply Director of Nu Kent General Hospital, Dover, Del.

OPERATING ROOM NURSE P.M.: 1 general hospital located in a beautiful dential suburb along the North Shore o cago. Modern ranch style nurses home attractively furnished private bedrooms. wk. $375 per mo. Other employee be Contact Personnel Director, Highland Hospital Foundation, Highland Park, Ill

OPERATING ROOM NURSES: 370 be proved gen. hosp. with an interne-reside gram. 7-theatre, 650 to 750 cases mo $330 or $340 per mo starting salary acc to experience. $20 per mo merit increa 12, 24 and 36 mos. 40 hr wk, 2 wks pd tion, pd sick lv, 7 pd holidays. Resort lo in California's finest recreational area. to: Director of Personnel, Seaside Me Hospital, 1401 Chestnut Ave., Long Be Calif.

OPERATING ROOM NURSES: Moder bed hosp, salary averaging $370, 1½ ove 4 $10 annual increments, 7 pd holidays, vacation after 1 yr. Director of Nurses, pic Memorial Hospital, Port Angeles, W

OPERATING ROOM SUPERVISOR: 5 voluntary hosp. Degree and/or satisfacto perience. Active program-clinical inst employed for teaching students. Salary mensurate with qualifications. Libera sonnel policies. Direct transportation t in 35 mins. Write to: Director of N Newark Beth Israel Hospital, Newark 1

OPERATING ROOM SUPERVISOR: 2 hosp, 40 hr wk. Salary commensurate w perience and qualifications. Apply Dir of Nurses, St. Mary's Hospital, West Beach, Fla.

OR & GENERAL STAFF NURSES: 2 general hospital located nr Grand T Bay in the heart of summer vacationla mi north of Grand Rapids. Scheduled Airline service from Detroit and C Basic rate $273 with automatic increa hr 5 day wk and bonus for on-call dut holidays, 2 wks vacation, 10 days s cumulative to 50 days, Social Security laundering of uniforms. Nurses re under construction. Write to Director o

Beginner

It isn't right to be likened to a kite, but this boy is in the soft, white clouds. He likes today and doesn't fret about tomorrow. All he wants is to get somewhere now. First things first for this tyro, he's training for the grand flight ahead.

Yes, he's a master, faster beginner. He is an S-M-A baby.

Sound Infant Nutrition

Wyeth®
Philadelphia 1, Pa.

S-M-A
Concentrated Liquid
Instant Powder

This advertisement conforms to the Code for Advertising of the Physicians' Council for Information on Child Health.

ing, James Decker Munson Hospital, Traverse City, Mich.

OR SUPERVISOR: 50 bed privately owned gen hosp, college town 10,000 pop, close to Kansas City and Whiteman Air Force Base. Prefer experience, but will consider a graduate. Salary open. Warrensburg Medical Center, Inc., 122 East Market, Warrensburg, Mo.

PEDIATRIC EDUCATIONAL DIRECTOR: 100 bed pediatric medical center, Temple University connection. Affiliating student program. Masters Degree preferred, will accept B.S. with experience. Salary commensurate with qualifications, 30 days vacation, 7 holidays, 14 days sick lv. Write Director of Nursing, St. Christopher's Hospital for Children (non-sectarian), 2600 N. Lawrence St., Philadelphia 33, Pa.

PROFESSIONAL NURSES: Immediate openings for Head Nurses at the rate of $6420 per annum. Ass't Head Nurses at the rate of $5340 per annum. Staff Nurses at the rate of $4860 per annum. Guaranteed annual increases. 40 hr wk, shift differential, 4 wks pd vacation, 7 pd holidays. Social Security plus non-contributory retirement plan. Sick lv plus employees health program. Send card or letter to: Miners Memorial Hospital Association, Box 61, 110 Logan St., Williamson, W. Va.

PROFESSIONAL NURSES FOR CALIFORNIA: Streamlined procedure for immediate appointment at Veterans' Home and State Hospitals. No experience needed to start at $358, raise to $376 after 6 mos. Nurses with 1 year of psychiatric experience start in mental hospitals at $376, raise to $395 after 6 mos. Opportunities for promotion in mental hospitals up to $710. In-service training in psychiatric field. Openings for Surgical Nurses at $376. Require Calif. license. Employment interviews in New York the first week of June, see the State representative at ANA Convention Exhibit No. 230, Atlantic City, June 9-13. Secure details from State Personnel Board, 801 Capitol Ave., Box 123, Sacramento, Calif.

PUBLIC HEALTH: (a) Asst. prof. fully accred. college prog. in medical center of 60,000. 9 mo. apptmt. $5-7600, S. (b) Chief for combined county P.H. dept and VNA, West Coast, to $8700. (c) Nursing Consultant, generalized prog of mountain state P.H. Dept, W. To $6500. RN-6 Burneice Larson, Medical Bureau, 900 N. Michigan Ave., Chicago, Ill.

PUBLIC HEALTH STAFF NURSES (2): Service covers Borough and vicinity, agency cars. Qualified supervision. Starting salary, R.N. $3240, PHN I $3500, PHN II $4000. (PNA qualifications standards). Increments every 6 mos for 3 yrs. Good personnel policies. Apply Director of Visiting Nurse Service, Carlisle Hospital, Carlisle, Pa.

R.N.: For Adelphi College Health Service, academic year 1958-59. Office hrs. 9-5 plus every other weekend duty in dormitory. Total salary $3800. Refer all inquiries to John E. Gillick, M.D., Adelphi College, Garden City, N. Y.

R.N.: For women's dormitory infirmary, small college. Live in. New buildings. Easter, Christmas and summer vacation. Personal interview required. Box 150, Albion, Mich.

R.N.s: Needed to staff enlarged hospital Salary commensurate with ability. Vacation, sick leave, Social Security, living accommodations if desired. Days drive to many scenic national

parks. Wire Director of Nursing Service, Utah Valley Hospital, Provo, Utah.

R.N.'s: Positions available at Merced County General Hospital. All shifts, obstetrics, surgical ward and other areas. In-service training in area of choice. For full information write Director of Nursing Services, P. O. Box 231, Merced, Calif.

REGISTERED NURSE: Instructor in nursing technique. Experienced, for training aides. 286 bed sanitarium. Apply Dr. Joseph O. Smigel, Pinehaven Sanitarium, Pinewald, N.J. Telephone: Toms River 8-2050.

REGISTERED NURSE: For Riverdale Country School, day and boarding school on edge of NYC. Head infirmary nurse, must live in. Riverdale Country School, 253rd St. & Fieldston Road, New York 71, N. Y.

REGISTERED NURSE: Intravenous Therapy and Blood Bank. 210 bed teaching hosp, 35 mi from NYC. $290 per mo, 40 hr wk, regular increments. Good personnel policies, living facilities available if needed. Experience not required. Call or write Director of Nurses, White Plains Hospital, White Plains, N.Y., WH 9-4500.

REGISTERED NURSES: For air conditioned gen hosp. expanding to 200 beds. Organized medical staff, pleasant working conditions. Reasonable accommodations in nurses residence. Starting salary $277 per mo, 4 wks annual vacation with sick lv and holidays. Apply Director of Nurses, John D. Archbold Memorial Hospital, Thomasville, Ga.

REGISTERED NURSES: Staff duty, PM, nights and relief shifts. Permanent community. Small modern hospital 14 beds. $375 per mo. Social Security, 2 wks pd vacation and 40 hr wk. Lillian M. Maupin, R.N., Administrator, Seneca Hospital, Chester, Calif.

REGISTERED NURSES: If you are thinking of making a change consider the opportunities at Cuyahoga County Hospital in Metropolitan Cleveland. Your starting salary as a staff nurse is $3744 and in 36 mos you will be earning $4170. You will also enjoy a pd vacation, holidays, sick time and a generous differential for eve and night assignment. If you prefer to continue your education, pd tuition to a college of your choice is available. The hospital is conveniently located to several colleges and universities. All of the advantages that a large hospital has to offer are at your fingertips, retirement benefits, wide variety of clinical fields from which to choose, a planned orientation and in-service program, opportunity for promotion and comfortable low-cost housing. Write to Director of Nursing, 3395 Scranton Road, Cleveland 9, Ohio

REGISTERED NURSES: Openings due to retirement. 600 bed Tuberculosis Hospital located 40 mi south of Jackson. Beginning salary $200 mo. with full maintenance. Merit increases. Personnel policies also include retirement pension plan, Social Security, 15 days vacation, 15 days sick lv and 6 annual holidays. Write Director of Nursing, Mississippi State Sanatorium, Sanatorium, Miss.

REGISTERED NURSES: Gen. duty, 25 bed hosp, starting salary $300 per mo. Room & Board. 40 hr wk, rotating shifts. 8 holidays, sick lv, vacation. Apply to Director of Nurses, Mt. Grant General Hospital, Hawthorne, Nev.

REGISTERED NURSES: For 105 accredited gen. hosp. Salary $330-$360 per mo, 40 hr wk, liberal vacation, holiday & sick lv. plan.

D WE ASK YOU ?

superior cleansing and refreshing effect

Pleasant aroma – no tell-tale medicinal odor

Meta Cine is more soothing and refreshing than other douche powders

thoroughly cleanses – and the clean feeling lasts much longer

I like it better than anything I have ever used

Leaves a cooling clean feeling

Cool, fresh, clean!

Gives a "tingling" feeling of cleanliness

Recently, we asked a representative cross-section of RN's who had used Meta Cine why they preferred it to other douches. As professional women, all recognized the scientific rationale of its judicious formula.

But the great majority (85%) spoke most highly of the esthetic and physiologic superiority of Meta Cine. A few representative comments are reproduced above. May we ask *you*—if we haven't already—to try Meta Cine, and compare it with any other douche?

If your favorite druggist doesn't happen to have Meta Cine in stock, he can easily order it for you from his wholesale supply house. Meta Cine possesses the physiologically correct pH of 3.5, and contains the mucus digestant, *papain; lactose*, to promote growth of desirable Döderlein bacilli; *methyl salicylate*, to stimulate circulation; and *eucalyptol, menthol* and *chlorothymol* for their decongestant and aromatic properties.

Meta Cine is supplied in 8-oz. containers. Promoted exclusively to the medical and nursing professions.

AYTEN PHARMACEUTICAL COMPANY

Chattanooga 9, Tennessee

THE TABLE OF TOMORROW—HERE TODAY...S-1501

SURG-A-MATIC BY SHAMPAINE

FEATURING EXCLUSIVE PUSH-BUTTON SHIFT

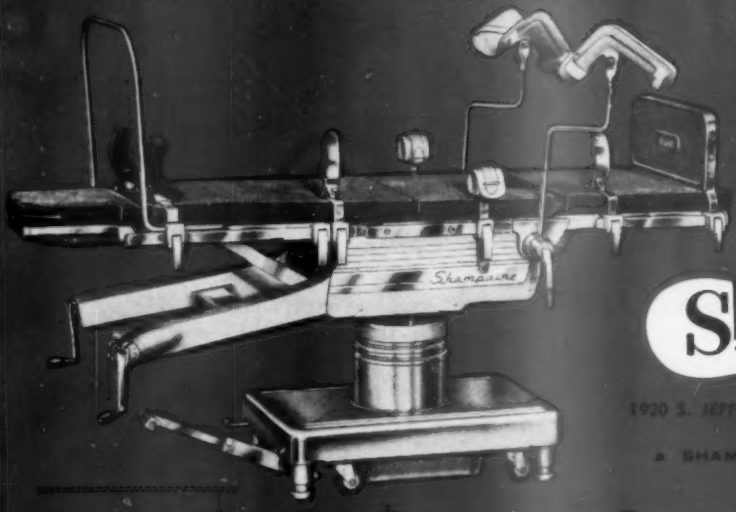
PUSH-BUTTON SHIFT—For selection of all positions—including single adjustment proctoscopic, compiete flex, reflex and kidney elevator.

TRUE HEAD-END CONTROL—All controls face anesthetist—outside draped and sterile field. No search at sides of table to check indicators or reach controls.

NEW BASES—Motorized or hydraulic—see details below.

FAST ACTING SIDERAIL CLAMPS—Eliminate broken or easy-to-lose set-screws. Accessories easily attached or detached.

NEW CRUTCH SOCKETS—Quick acting friction lock clamps speed adjustment of leg holders. Self-locking socket holds rod in any position.

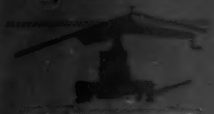


Shampaine COMPANY

1920 S. JEFFERSON • ST. LOUIS

A SHAMPAINE Si industry

SURG-A-MATIC provides table top heights from 27" minimum to 45" maximum.



SURG-A-MATIC provides kidney elevator adjustment off push-button shift.

SURG-A-MATIC provides complete 139 degree flex.

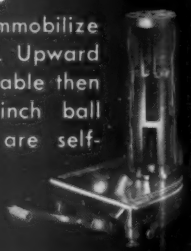
SURG-A-MATIC provides ... adjustment ... scopic position.

NEW BASES—MOTORIZED OR HYDRAULIC

Three widely spaced rods in pedestal give table top maximum support. No lateral whip. No exposed keyways.

Motor concealed in base—no external housings. Motor listed with Underwriters Laboratories for class "1" group "C" atmosphere.

Down strokes of pedal immobilize table on hydraulic jacks. Upward pressure retracts jacks. Table then moves easily on three-inch ball bearing casters. Jacks are self-leveling on normal floor.



ly Director of Nurses, Glenn General pital, Willows, Calif.

GISTERED NURSES: For general duty in ern general 50 bed hosp. in scenic Rocky town of 5000. Excellent climate and living ditions, fine medical staff, congenial nurs- staff with high nursing standards. Write R. Coe Memorial Hospital, Cody, Wyo.

GISTERED NURSES: Geriatrics, a new of nursing, opens for you at Pinehaven itarium, a 290 bed institution for the care the aged, chronically ill. Easier duties, lieu of retiring. Beautiful surroundings, genial associates. Salary $240 per mo, full maintenance, and other benefits. ly Pinehaven Nursing Home and Sani- um, Pinewald, N. J., Dr. Joseph O. Smigel, ical Director. Phone Toms River 8-2050.

GISTERED NURSES: For general duty, rida East Coast 70 bed JCAH fully ac- lited gen. hosp. Salary range $265 to $295 mo, $10 differential for 3-11 and 11-7 ts, 40 hr wk, 6 pd holidays, 2-4 weeks ation, 15 days sick lv cumulative to 45 . Contact Director of Nurses, Fort Pierce morial Hospital, Fort Pierce, Fla.

GISTERED PROFESSIONAL NURSES: 500 bed general medical & surgical Vet- s Administration Hospital, Dallas, Texas. bed expansion in summer of '58. Per- nel policies normally include 40 hr wk, days annual lv, 15 days sick lv, 8 holidays, ual pay increment and free laundry of forms. Minimum annual salary $4025. itions available. Contact Chief, Nursing vice, VA Hospital, Dallas, Tex.

GISTERED PROFESSIONAL NURSES: supervisory, teaching and general staff tions. Salary commensurate with educa- and experience. Base salary starts at per mo with $30 monthly p.m. and night erential plus $2 bonus for Saturdays, Sun- and holidays worked. Unused sick lv. nbursed. Other benefits. Progressive per- nel policies. 250 bed JCAH approved teach- hosp. on Northside Chicago near educa- al, cultural and recreational activities. mins. from Chicago Loop. Reasonable, good g accommodations nr hosp. Write to Di- or of Nursing, Ravenswood Hospital, Wil- Ave. at Winchester, Chicago 40, Ill.

GISTERED PROFESSIONAL NURSES: supervisory, educational and general staff tions. Liberal personnel policies. 40 hr differential for eve, nights and OR. al Security. Christ Hospital, 176 Palisade . Jersey City, N.J.

HABILITATION NURSING AT CHIL- EN'S CENTER: Opening for R.N. inter- d in rehabilitation. Experience not neces- . Top salaries, liberal policies. Crotched intain Rehabilitation Center, Greenfield.

HOOL OF ANESTHESIA: Approved by the NA. Open to registered nurses of accredited ols of nursing. Applications being re- ed for August and February classes. For plete information and application blanks te to Everard R. Hicks, Director of The ol of Anesthesia, The McLeod Infirmary, rence, S.C.

HOOL NURSE: West Coast Girls' Board- and Day School, delightfully located, needs lent registered nurse Sept. 1958. Attrac- living, good salary for 9 mos a yr. Write ie Wright Seminary, Tacoma 3, Wash.

HOOL NURSES: (a) Infirmary Superv., ent health service of 2300, coed univ, $300 complete mtce, West. (b) Exclusive school young ladies, most congenial associates,

beautiful campus overlooks Sound. Attrac. liv. qtrs. $300. NW. RN6-7 Burneice Larson, Medical Bureau, 900 N. Michigan Ave., Chicago, Ill.

STAFF: (a) Small Hawaiian plantation hsp, $3600 plus. (b) Four, 350 bed hsp, Pacific Island, important U. S. Naval Base. $4800, housing. RN6-8 Burneice Larson, Medical Bureau, 900 N. Michigan Ave., Chicago, Ill.

STAFF GRADUATE NURSES: All shifts, medical-surgical and obstetrical areas. 384 bed hospital. Salary $325 to $360 in 18 mos, $1.50 differential for eves, $1 for night service. Liberal personnel policies. Hospital within walking distance of Wayne State University. Apply Personnel Dept., Woman's Hospital, Detroit 1, Mich.

STAFF NURSE: Positions open, good personnel policies, salary starts at $330 per mo, teaching hospital, university town. Please write to: Director of Nursing, University Hospital, Ann Arbor, Mich. for further information.

STAFF NURSES: 250 bed hosp, 40 hr wk. Vacancies for graduate and practical nurses fo: OR, Recovery Room, Obstetrics, Emergency, Delivery Room, Medical & Surgical Nursing. Apply to Directress of Nurses, St. Mary's Hospital, West Palm Beach, Fla.

STAFF NURSES: 425 bed modern hosp. in central Florida city, near Gulf Beaches. Starting salary $245 for days, $260 eves. and nights. Good personnel policies, annual increases, 8 pd holidays, sick lv and vacation. Apply Director of Nurses, Mound Park Hospital, St. Petersburg, Fla.

STAFF NURSES: 365 bed hospital, starting salary $325 mo. for days, $390 mo for eves. and nights, 12 sick days, 6 holidays, 2 wks vacation per yr, 3 wks vacation after 5 yrs. Increments every 6 mos. No housing hospital premises but available in the ne borhood. Apply Associate Director, Nur Service, St. Anne's Hospital, 4950 W Thomas St., Chicago 51, Ill.

STAFF NURSES: Modern expanding 225 general hospital located on the Shore of L Erie in residential suburb of Cleveland, proved by JCAH. Salary range $290-$ Afternoon-night differential to $325. Sch uled increments based on experience and p formance, good personnel policies, nonrota assignment, service of preference conside Well-known for friendly atmosphere. Liv quarters available in Nurses' Residence at cost. Write Director of Nursing, Euclid G ville Hospital, Euclid 19, Ohio

STAFF NURSES: 210 bed general hosp. cated in the "Oil Capital of the Rockies" main route to Yellowstone Park. Minim salary $285, merit increases considered nually, 40 hr wk, 6 pd holidays, 2 wks v tion. 12 days sick lv, cumulative to 60 d Uniform laundry furnished. Rooms avail $20 mo. See June '56 issue Modern Ho tal for information about hospital. W Director of Nursing Service, Memorial H pital, Casper, Wyo.

STAFF NURSES: 225 bed Southern Califo hospital on ocean front. Attractive perso policies. Salary for California regist nurses starts at $300. Increases on m Apply to Director of Nursing, Santa Bar Cottage Hospital, Santa Barbara, Calif.

STAFF NURSES FOR METABOLIC UN If you want to do something different, the metabolic team on attractive 8 bed Salary $295-335. 6 hr eve. duty, 6 pd holi 3 wks August vacation. Pd transport

ARE YOU A NURSE

Who's Thinking About Her FUTURE?

You'll want to read this EXCITING FOLDER!

LIVE YOUR

"7-Feature Future"

AT

UNIVERSITY HOSPITAL

OF THE GOOD SHEPHERD

Syracuse University
Syracuse 10, New York

FREE TUITION at SYRACUSE UNIVERSITY!

- **FOR YOU**—to complete your nursing education—BS, MS, MA—under our remitted tuition plan now in force.
- **FOR YOUR COLLEGE-AGE CHILDREN**—full scholarships . . . average value $1,000 per year . . under our unique plan presently available to all full-time RN staff members at University Hospital.

Send NOW for this 7-FEATURE FOLDER

Describing tuition and other benefits available to you as a nurse at University Hospital!

Miss Adele Wright, RN,
Director of Nursing Services
University Hospital
150 Marshall Street, Syracuse 10, N. Y

Please send me University's "7 Feature" Folder I am interested especially in ☐ RN tuition plan; ☐ helping my children through college

Name _____

Address _____

City _____ Zone _____ State _____

UNIVERSITY HOSPITAL OF THE GOOD SHEPHERD is accredited by the Joint Commission on Accreditation of Hospitals.

from within United States. For further information write or wire Director Nursing Service, University Hospitals of Cleveland, 2065 Adelbert Rd., Cleveland, Ohio.

STAFF NURSING: Immediate openings for Staff Nurses, good salary, Social Security, vacation, sick leave, 40 hr wk, 2 meals, laundry, college town. Call or write Mrs. Edwina McKnight, Director of Nurses, Floyd Hospital, Rome, Ga.

SUPERVISOR-INSTRUCTOR: JCAH accredited 210 bed gen hosp, NLN temporarily accredited school of Nursing, has opening for supervisor-instructor in Obstetrics, 31 bed dept. averaging 100 deliveries per mo. Responsible for formal instruction, supervision of students' clinical experience and nursing service supervision. Academic preparation and experience req'd. Good personnel policies. Apply Director of Nursing, White Plains Hospital, White Plains, N. Y. WH 9-4500.

SUPERVISORS: (a) Ready to assume responsibility nursing service, 80 bed hsp, leading M.W. city, univ. center, to $7200. (b) Practical Nurse Supv. Instructor, 400 bed hsp, Ohio. $4800 up. (c) OR, small gen hsp nr Kansas City, college town. $4800. (d) Surg. supv, oversee 3 units of 77 beds, no teaching req, lge gen hsp. $5400, East. RN-6-9 Burneice Larson, Medical Bureau, 900 N. Michigan Ave., Chicago, Ill.

SURGERY SUPERVISOR: Qualified to assume administrative duties in large OR suite, located in new 4 story surgical wing. Liberal salary and personnel policies. Write or wire Assistant Administrator, Personnel Dept., San Jose Hospital, San Jose, Calif. 50 mi from San Francisco in sunny Santa Clara Valley.

SUTURE NURSES: Work with top nurses and surgeons. Opportunity experience in radical procedures, 5 day wk schedule. Teachers College learn-earn plan now open to operating room nurses combines study with experience at full salary. Good basic preparation needed, learn specialty here. $300-340 mo. plus ½ pay for on-call hours. 4 wks vacation, other benefits. See our ad High Caliber Registered Nurses. Thelma Laird, R.N., Director of Nursing, Memorial Center, 444 E. 68th St., New York 21, N.Y.

Rates for **POSITIONS AVAILABLE** advertisements are as follows: $9.00 minimum charge for three lines (approximately 20 words). $2.50 for each additional line (6-7 words). Closing date is the first of month preceding date of publication.

Additional Listings

Space permits listing the following vertisements in this issue, although were received after closing date.

EDUCATIONAL DIRECTOR: Masters D and experience in teaching desirable. Li personnel policies. Admit 1 class a ye yr diploma program, 184 bed hospital, 52 dents. Basic sciences taught at Trenton ior College. Positions open Aug. 15, '58. A to Director of Nurses, McKinley Hos Trenton, N.J.

GENERAL STAFF NURSES: New 40 hosp in ranching and farming communi 2500 population. Good climate, close to m tains. 40 hr wk, 8 hr day, pd vacation an ary increase after 1 year service. Startin ary $275 mo., differential for 3-11, 11-7 s Apply Director of Nurses, Platte C Memorial Hospital, Wheatland, Wyo.

INSTRUCTOR-TUBERCULOSIS NURS Classroom and clinical teaching, small g of affiliating students. Other instructor employed. Emphasis on the individual long-term illness. Modern accredited t culosis hospital with excellent facilities, personnel policies. Degree required, p ably in Education. Some experience in t culosis or long-term nursing desirable. tact Miss Margery Jarmon, Director of ing Service, Emily P. Bissell Hospital, Newport Gap Pike, Wilmington, Del.

NURSE ANESTHETIST: For 200 bed h tal. New hospital being contructed. S open. Apply Nathan I. Kantor, M.D., Anesthesia, Warren Hosp., Phillipsburg,

NURSES: Registered, openings on all s Salaries and other benefits comparable to hospitals. Write Director of Nurses, G Hospital, 2307 W. 14th St., Clevelan Ohio.

REGISTERED PROFESSIONAL NUR This is your opportunity to re-locate in S ern California. Choice positions open n modern new 100 bed general hospital. salary $315, $20 differential for after and nights, $10 for special services. Y raises. Time and one-half over 40 hr vacations, holidays, sick lv, hospital insur Apply to Director of Nurses, Rio Hondo orial Hospital, 8300 Telegraph Road, Ri Calif.

3 ECONOMICAL WAYS TO INCREASE PROTEIN IN GERIATRIC DIETS — Extra protein in extra-flavorful form to tempt the geriatric patient who balks at bland food.

For breakfast—at only 3¢ per 1 oz. serving.

Gerber High Protein Cereal supplies approximately 10 grams protein from oats, soya, wheat gluten and yeast, scientifically blended for a good assortment of amino acids. Its nut-like flavor has grown-up appeal. Conveniently ready to serve with milk, hot or cold.

For dinner—at about 23¢ per 3½ oz. serving.

Gerber Junior Meats provide an average of 18.5 grams high quality protein from selected Armour cuts. Their fat content is very low – much less than home preparations can give. Their minced texture and savory goodness overcome chewing problems and poor appetite. Beef, Lamb, Pork or Veal.

For supper or lunch—at about 19¢ per 4¾ oz. serving.

Gerber's High Meat Dinners yield more than 9 grams protein. These Gerber-pioneered products contain three times as much meat as regular vegetable and meat combinations. This extra meat is combined with selected vegetables and cereal for unusual flavor interest and a generous assortment of nutrients. Three varieties – Beef, Chicken, Veal. Strained or Junior (minced).

Like all Gerber Foods, the High Protein Cereal, Meats and High Meat Dinners are ideal for live-aloners. They require little preparation – are readily and economically available at grocery stores.

Gerber. Products

FREMONT, MICHIGAN

Amazing New Way Relieves Blemishes Faster

"Full Treatment" Usually Brings Softer, Lovelier Skin Within 5 Days

Most skin medication takes weeks to work, but Cuticura relieves blackheads and pimples in a few days—and new softness, new freshness, exciting new radiance begins!

For fast results get all three—get the full treatment!

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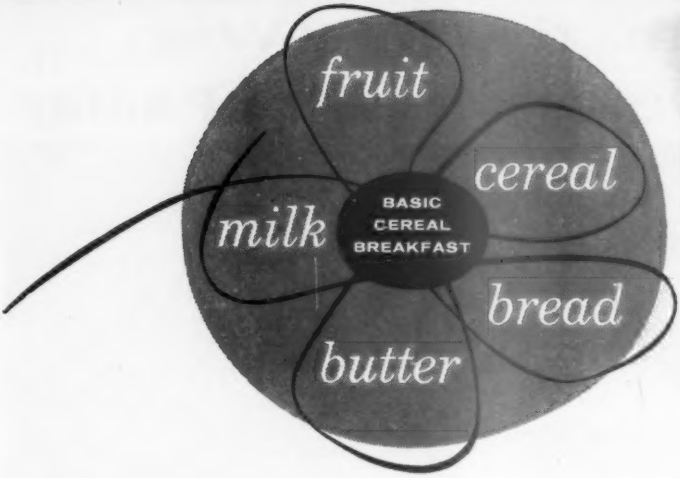
Cuticura has said for years—

Wishing won't help your skin, Cuticura will!



what is a well-balanced *low-fa* quick and lasting energy breakfast

What is meant by "Quick and Lasting Energy"? It is a prompt "lift" due to a quick rise in blood sugar—a lasting "lift" due to the fact that the blood sugar remains up and falls only gradually during the late morning hours.

The Iowa Breakfast Studies demonstrated th basic cereal and milk breakfast as shown b provided quick and lasting energy. This basic br fast is *low in fat* and makes a well-balanced d tribution of the essential nutrients.

basic cereal low-fat breakfast pattern

Orange juice, fresh, ½ cup,
Cereal, dry weight, 1 oz.,
with whole milk, ½ cup, and sugar, 1 tsp.,
Bread, white, 2 slices, with butter, 1 tsp.,
Milk, nonfat (skim), 1 cup,
black coffee

Nutritive value of basic cereal breakfast pattern

CALORIES	502	VITAMIN A	600 I.U.
PROTEIN	20.5 gm.	THIAMINE	0.45 mg.
FAT	11.6 gm.	RIBOFLAVIN	0.60 mg.
CARBOHYDRATE	80.7 gm.	NIACIN	3.0 mg.
CALCIUM	0.532 gm.	ASCORBIC ACID	65.5 mg.
IRON	2.7 mg.	CHOLESTEROL	32.9 mg.

Note: To further reduce fat and cholesterol use skim milk on cereal which reduces Fat to 7.0 gm. and Cholesterol Total to 16.8 mg. Preserves or honey as spread further re Fat and Cholesterol.

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Hayes, O. B., and Rose, G. K.: Supplementary Food Composition Table. J. Am. Dietet. A. 33:26, 1
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ENZYME-CONTROLLED ANTIFUNGAL AGENT

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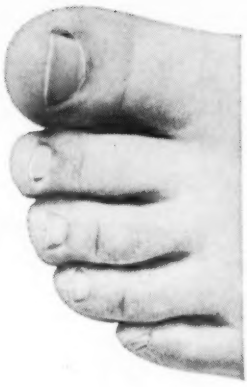
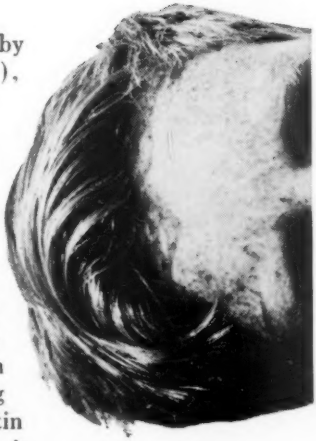
in superficial mycotic infections particularly tinea pedis and t. capitis



"ENZACTIN" Cream

Brand of Triacetin (in emollient base)

nonirritating • nonsensitizing • odorless • stainless



The unique mode of action of triacetin, discovered by Knight[1] (Wisconsin Alumni Research Foundation), stems from the fact that the release of free fatty acid (acetic) from the triacetin "reservoir" is controlled by the activity of esterase, an enzyme abundantly present in skin, serum, and fungi. Conversely, esterase activity which decreases as acidity increases, is controlled by the pH of the environment.

This self-controlled enzyme action thus insures a constant level of free fatty acid within a pH range of greatest therapeutic effect, but in a concentration that is nonirritating to the tissues even over long periods of time. The clinical effectiveness of triacetin against a wide range of common dermatophytes is amply confirmed by Johnson and Tuura.[2]

Supplied: "Enzactin" Cream No. 201 — 250 mg. glyceryl triacetate per gram (in emollient base), 1 oz. collapsible tubes.

Bibliography and literature on request

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